OFFICE OF THE
CITY AUDITOR
ENSURING OPEN AND ACCOUNTABLE GOVERNMENT

CITY OF PORTLAND

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November 24, 2014

To: Mayor Charlie Hales
Commissioner Nick Fish
Commissioner Amanda Fritz
Commissioner Steve Novick
Commissioner Dan Saltzman

From: City Auditor LaVonne Griffin-Valade

Re: OIR Group – Review of eight officer-involved shootings and one in-custody death

The attached report presents the results of the OIR Group's review of closed investigations pertaining to the in-custody death of Darris Johnson in July 2011 and these eight officer-involved shootings: Dupree Carter – December 2006; Steven Bolen – May 2007; Jeffrey Turpin – October 2007; Derek Coady – May 2008; Craig Boehler – November 2010; Darryll Ferguson – December 2010; Marcus Lagozzino – December 2010; and Ralph Turner – March 2011. The quality of the criminal and administrative investigations of such events is of particular importance to City leaders and the community at large. The Portland Police Bureau is expected to conduct thorough investigations of use-of-force incidents, glean any learnings, identify areas of concern, take any necessary disciplinary action, and/or modify policies when appropriate.

Since 2003, the City Auditor has contracted with two outside experts to examine such events: PARC (four reports between 2003 and 2009) and the OIR Group (2010 report on the in-custody death of James Chasse, the 2012 report on seven officer-involved shootings, and the 2013 review of six officer-involved shootings and one in-custody death).

Due to the length of time it has historically taken the City to finalize investigations, a number of the incidents discussed in the attached report occurred several years ago. Older cases warrant as much scrutiny as recent ones, and may offer an opportunity to explore whether the Police Bureau used the knowledge gained from past incidents to improve the organization. As with previous reviews of the closed investigations, the OIR Group found lapses in the Bureau's ability to effectively learn from past incidents and make the necessary changes to policies and training.

The US Department of Justice has imposed certain reforms on the Bureau aimed at reducing use-of-force incidents, particularly with individuals in mental health crisis. Assessing the long-term impact of those reforms on organizational police culture will require time and ongoing reinforcement by Bureau leadership, City Council, and the wider community. Future evaluations, including reviews of closed investigations by outside experts, will be important in understanding whether real change has taken place.

Report to the City of Portland on Portland Police Bureau Officer-Involved Shootings and In-Custody Deaths

Third Report • November 2014

OIR GROUP
Michael Gennaco
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Table of Contents

Foreword

With the eight officer-involved shootings and one in-custody death we review in this report, we have now examined 24 critical incidents involving Portland Police Bureau officers. In 21 of those incidents, officers have been constrained to use deadly force, and in three, individuals have died after being taken into police custody. While each incident is accompanied by its unique set of facts, patterns have begun to emerge as we examine the incident itself, how the Bureau investigated and reviewed the incident, and what lessons and corrective actions the Bureau developed to ensure accountability and better prepare its members to handle future critical incidents.

Unlike our first two reports, this report is not organized around a theme but rather captures a snapshot of events over a span of four and a half years. Many of the incidents reviewed for this report involve officers confronting subjects at the doors of their homes. We see through these cases how various degrees of tactical planning and preparation can affect outcomes.

Regarding the Bureau's investigative responsibilities, we continued to see in the cases reviewed for this report generally good, thorough, and objective work by Bureau investigative personnel, within both Detectives and Internal Affairs Divisions. It is particularly remarkable how Detectives are able to pull the facts together in an investigative report for the District Attorney to use in his

presentation to the grand jury in a matter of days, not months. With some notable exceptions, we have also favorably reported on how Internal Affairs (IA) investigators scope their investigations more broadly than the decision to pull the trigger and examine tactical decision making, supervisory issues, and post-incident responses. Even though the combination of the Detectives and IA investigations generally meets the mark, there are times noted in this report in which witnesses to officer-involved shootings were not interviewed and potential evidence was not collected due to reliance on civilian witnesses about whether video surveillance equipment was functioning or not. For that reason, we advocate development of more formal protocols for investigators with regard to who needs to be interviewed and how potential video evidence is to be collected.

Because we have been impressed with the objectivity and skill displayed by Portland Police Bureau (PPB) detectives on the criminal side, we are struck by the Bureau's continued inclusion of non-Bureau detectives as part of the investigative team for the eastern part of the City. The repeated use of leading questions and pre-interviews by non-Bureau investigators is indicative of an orientation that is neither neutral nor consistent with best practices and potentially undermines the work done by PPB personnel. Either non-Bureau personnel need to be oriented and trained to operate consistently with Bureau expectations or the Bureau should again consider going it alone in investigating officer-involved shootings.

Another issue that still needs revisiting is the 48-hour period afforded officers before being required to provide a statement about an incident. For the Bureau to be required to wait two full days before hearing from the involved officers about what transpired to cause them to use deadly force is inconsistent with best practices. As with any investigation, the time immediately after an officer-involved shooting is the most important period in which to identify and collect evidence, identify witnesses, and put a case together. Indeed, the PPB, like police agencies throughout the country, has investigators "roll out" immediately to critical incidents. For the Bureau's investigative machinery to be hamstrung by the refusal of involved officers to provide accounts of what occurred for at least 48 hours necessarily impacts the investigation and the public's confidence in that investigation. As a result of the status quo, the Bureau is delayed in learning about the participants' mind set and actions and, as a result, investigative leads are stalled and possibly foreclosed entirely.

We have also commented generally favorably about the process devised by the Bureau to review critical incidents. The analysis by the Training Division in

identifying issues can be exceptional with regard to thoroughness and rigor; the mere fact that any analysis is prepared by Training puts the Bureau's review process well ahead of many comparable law enforcement agencies. As noted in this report, however, we have seen instances in which the Training Division Review failed to identify significant issues. For that reason, we suggest that the Bureau consider whether other stakeholders might act as a supplement or complement to the issue identification process currently reserved for Training and the involved officers' Commander.

The Bureau spends much time and effort to push each critical incident through a detailed review process; it was thus disheartening to discover that in one case reviewed here, the recommendations coming out of the review and endorsed by the Chief were never implemented. Moreover, the more holistic and robust recommendations that had been a praiseworthy feature of the Police Review Board seemed to have dissipated somewhat, at least with regard to the critical incidents reviewed here. Thus, we advocate that the Bureau develop a more formalized mechanism to ensure that recommendations emanating from the Board and accepted by the Chief are in fact implemented. Regarding the work of the Review Board, we suggest that the framework of inquiry be channeled more formally so that the Board is specifically asked to render determinations regarding (1) performance of officers with regard to tactical decision making, (2) whether training or other remedial action should be recommended for the involved officers or Bureau-wide and (3) an assessment of the strength and quality of the investigations.

As we have charted out below, the Bureau has struggled with little success for over a decade to reduce the length of time that it takes to get cases investigated and through the review process. We urge the Bureau to redouble their efforts to shorten this process so that the time frames for completion begin to approximate best practices and so that corrective actions coming out of these investigations can take timely effect.

Finally, we have yet to see evidence of sustained improvement in providing medical assistance to injured subjects more rapidly. While we have not yet reviewed some of the more recent cases, we will continue to be looking for signs of improvement in this area as our review process moves forward.

What has remained consistent over the five years we have been reviewing critical incidents for the City of Portland is the cooperation we have received from the Bureau's executive team. In addition to providing assistance to us in a search for

relevant documents, training, policies, and practices, Bureau representatives have been uniformly candid and helpful in answering questions that aren't answered in the documents. Any insight that we are able to communicate to the reader here would not have been possible but for the information provided by those representatives and the sustained and steady cooperation of the Bureau's command staff. That orientation is not universally shared by all law enforcement agencies and is a testament to the Bureau's ongoing receptivity to hearing from outside voices.

In each of our reports, we review officer-involved shootings as a group in an effort to identify themes and trends that point to a need for the Bureau's attention. The current structure of the Bureau review process is to examine each shooting independent of others. As we do in our reports, we suggest that the Bureau also undertake on a periodic basis a more universal review of shootings and other major force incidents to identify common themes. The discovery of common links among critical incidents will provide the Bureau with a better understanding of where limited training resources could best be devoted. Whether such self-identification leads the Bureau to discover that a significant number of critical incidents involve approaches to a residence, planning and communication, foot pursuits, or dealing with persons in crisis, a more systemic examination of critical incidents is one method through which the Bureau can learn how best to prepare its officers to deal with similar issues in the future. The Bureau should consider scheduling such cumulative reviews periodically so that this type of self-examination becomes an institutional habit.

Scope of Review

The Portland City Auditor originally tasked OIR Group with reviewing 17 officer-involved shootings and one in-custody death involving the Portland Police Bureau that occurred from March 2004 to January 2011. In our first two reports, we examined 13 shootings and the one in-custody death. Since then, the City expanded the criteria for review to include any officer-involved shooting or in-custody death for which the Bureau's internal investigation was concluded by December 31, 2012. In this, our third report, we examine the three older incidents remaining from the original list of cases and another five shootings and one in-custody death. The review covers incidents that occurred over a span of four and a half years, from December 2006 to July 2011.

As we have done for our prior reports, we reviewed all of the PPB's investigative materials for each of the seven critical incidents, including the Detectives' and Internal Affairs (IA) investigations, as well as grand jury transcripts where available. We also read and considered the Training Division Review and materials documenting the Bureau's internal review and decision-making process connected with each incident. We requested, received, and reviewed relevant training materials and referred back to training materials we reviewed for our prior reports. We talked with PPB executives regarding questions that were not answered in the initial materials provided and requested additional documents that were responsive to those questions.

Our analysis centers on the quality and thoroughness of the Bureau's internal investigation and review of each of the incidents presented. We look at relevant training and policy issues, and corrective actions initiated by the Bureau. We do not opine on whether any particular shooting, or related tactic or use of force, is within policy. We do fault the Bureau, however, when we find issues that were not addressed or thoroughly examined by the investigation and review process that could have impacted the Bureau's findings on the appropriateness of the force or other tactical decision making.

As with our previous reports, this report contains three sections. Section One contains a factual summary of each of the nine critical incidents, along with an analysis of issues presented by each. Section Two is an analysis of themes and issues we identify that are common to several of the incidents. Section Three presents a list of all recommendations we make throughout this report.

SECTION ONE

Officer-involved shootings and In-Custody Death

Summary and Analysis

December 28, 2006 ◦ Dupree Carter

Just after Christmas, 2006, a 12-year-old girl went to a friend's home, a second story apartment in a four-unit building. While waiting in her car outside the building, the girl's mother encountered a man later identified as Dupree Carter, who confronted her and told her to "stop knocking on my fuckin' door." Mr. Carter held a gun at his side. The mother denied having knocked, and Mr. Carter walked away, only to return moments later following the girl as she returned to her mother's car to get something she had forgotten to give her friend. He made a similar comment to her about knocking on his door, which she similarly denied doing. The girl then returned to her friend's apartment and, on the way, Mr. Carter pointed the gun at her head, again telling her to stop knocking on his door. Mr. Carter then went into the second floor apartment across the landing from the girl's friend's home.

The girl's mother called the police, and PPB Officer Philip Harper responded, along with a sergeant and another officer. The officers and sergeant met a short distance from the apartment to get brief statements from the girl and her mother and to formulate a plan for addressing the threat. Other officers arrived and took positions around the perimeter of the apartment building. The officers evacuated the friend's apartment and discussed their options for getting Mr. Carter to exit his apartment. They looked at the apartment's mailboxes in an attempt to learn the individual's name and made several phone calls hoping to reach the individual, to no avail. The sergeant considered using a "loud hail" – announcements made via bullhorn or over a patrol car's PA system – to order Mr. Carter out of his apartment, but then decided there was no way to use the loud hail without exposing officers' positions. They also discussed the possibility of leaving without apprehending the individual, but dismissed this option as irresponsible, given the threat posed by a person willing to point a gun at a young girl for nothing more than knocking on his door.

Ultimately, the sergeant and his team formed a plan to have the sergeant knock on Mr. Carter's door and demand he come out. The officers took positions at the bottom of the stairway, with Officer Harper providing cover with his drawn firearm. The sergeant climbed the stairs but stayed in a low position to reach up to knock on the bottom of the door. He knocked repeatedly and loudly, sometimes using his flashlight to knock, while identifying himself as a police officer. There was no response from inside the apartment. He eventually gave up and had begun to descend the stairs when Mr. Carter cracked the door open and stuck his arm out. The other officer yelled, "gun!" or "door!" Mr. Carter was holding a semiautomatic pistol that he waved and pointed down the stairwell toward the officers. The sergeant crouched down and got to the bottom of the stairs as Officer Harper fired two rounds at the subject's arm. Both rounds missed, and the subject pulled his arm back into the apartment and closed the door.

Officer Harper broadcast his shooting and removed himself from the scene. The sergeant requested additional cover officers and a response from the Special Emergency Response Team (SERT) while he began to evacuate the lower apartment units. The sergeant stated that it was his plan to establish a perimeter around the building and wait for SERT. Despite this plan, the non-shooter officer continued to engage the subject from the bottom of the stairs, through the closed door. He identified himself as Portland Police and demanded that the subject come out. Within minutes, Mr. Carter's girlfriend emerged and surrendered.

Several minutes later, Mr. Carter came out of the apartment holding a baby in front of him. He was unarmed and surrendered to custody without incident. The officers then waited for SERT to clear the apartment, where they located Mr. Carter's gun.

When interviewed by Detectives, Mr. Carter admitted to getting angry about knocking on his door and, in response, taking his gun and confronting the girl and her mother. He denied ever pointing the gun at the girl, but said he held it at his side the entire time. He said he then went to bed and was asleep when his girlfriend woke him to say that someone was knocking on the door. He admitted to pointing his gun out the door to scare the person off, but denied hearing any police announcements.

Timeline of Investigation and Review

12/28/2006	Date of Incident
7/24/2007	IA investigation began
9/7/2007	IA Investigation completed
1/29/2008	Commander's Findings completed
2/27/2008	Use of Force Review Board

Analysis/Issues Presented

Insufficient Planning and Preparation

The sergeant and the officers discussed a plan for handling the threat posed by the armed individual that, according to one of the officers, "seemed real simple." However, the plan did not cover some critical issues and failed to account for contingencies. The sergeant said he considered the option of using a loud hail to draw the individual out of the apartment but dismissed it as unfeasible. In his interview later, however, he said he wished he had tried it. The other officers do

not recall this option being discussed. If the group had discussed this plan, the officers may have had a different view about the feasibility and the loud hail might have been successful.

The officers also did not consider the importance of evacuating the two bottom floor apartments prior to engaging Mr. Carter. One officer said, "I don't think we even gave it any thought." Had a gunfight erupted between Mr. Carter and the officers, this could have been problematic. The sergeant recognized this fact after the shooting as he evacuated the apartments while he planned to wait for SERT to handle the barricaded individual. However, the threat posed by Mr. Carter did not change significantly after the shooting. Officers knew going into the encounter that the individual had a firearm and was willing to point it in a threatening manner. It probably would have been most prudent to ask the lower floor residents to leave the building before drawing Mr. Carter out of his apartment.

Finally, officers did not consider their backdrop or the possibility that rounds might penetrate walls and strike unknown occupants of the apartment. In the end, one of Officer Harper's spent bullets was found on the floor of Mr. Carter's kitchen.

Sergeant's Tactical Role

Consistent with Bureau training and expectations, the sergeant responded to this incident to assume a supervisory role. He led the planning discussions and coordinated the post-incident response, as a field supervisor is expected to do. However, his decision to take the role of climbing the stairs to knock on Mr. Carter's door took him out of his supervisory role and put him in the middle of the tactical situation. The sergeant had sufficient resources and personnel available, and plenty of time to wait for a team of officers to be assembled so that he could have maintained his supervisory position. This issue arose in two of the shootings we reviewed in our Second Report. As we said there: "When the Bureau is fortunate enough to have sergeants on the scene of a tactical incident, it should count on those supervisors to take command of the incident and direct resources appropriately." Here, the sergeant's personal engagement in the incident may have prevented him from having a view of all the circumstances and surrounding issues.

Failure to Wait for SERT after the Officer-involved shooting

After the shooting, Officer Harper appropriately removed himself from the scene, and the sergeant began evacuating the lower level apartments while, he said, he intended to wait for SERT to respond to assume control of the incident. The sergeant, however, did not direct the officer to step back from the stairway and disengage. Instead, the officer maintained his position and continued to call for the individual to come out of the apartment. Where moments earlier there were three officers prepared to engage Mr. Carter, the officer stood alone essentially asking for an encounter with an armed person. Fortunately, the occupants of the apartment all came out and surrendered, but there was great potential for a disastrous outcome. Had Mr. Carter come out shooting or, even worse, come out shooting while holding the baby, this incident could have ended in tragedy.

Quality of Investigation and Review

Training Review and Commander's Memorandum Fail to Address Critical Issues

The Training Division Review of this incident evaluated the various decision points in this incident, but was almost exclusively laudatory. The only critical issue raised was the sergeant's decision not to request or wait for a long gun to cover the location as he and the other officers engaged Mr. Carter. While this would have been a useful resource, and Training appropriately raised this issue, the analysis failed to even identify the concerns raised above:

- The decision not to evacuate the building's other occupants.
- The sergeant's decision to assume a tactical role unnecessarily while sacrificing his ability to maintain a supervisory perspective.
- The failure to contemplate the penetrating ability of rounds fired during the encounter.
- The continued engagement of the non-shooter officer after the shooting. The training analysis notes that the officer "continued to yell commands toward the apartment from the bottom of the stairwell," but raises no concerns about the wisdom of this while praising the sergeant's

> management of the scene after the shooting. The post-shooting analysis focuses exclusively on the sergeant's quick removal of Officer Harper from the scene, and commends the sergeant for taking care of his officers.

The Commander's Memorandum likewise does not address any of these issues. It raises just two critical issues: the failure to wait for a long gun, and the sergeant's failure to immediately sequester Officer Harper, who went to the command post and was engaging with displaced residents and directing other officers into the scene for several minutes before a different sergeant assigned another officer to monitor him. Indeed, the Memorandum seems to misstate the facts with respect to the non-shooter officer's continued engagement and the failure to wait for SERT when it notes that "[t]he incident transitioned into a barricaded subject and established procedure was followed."

This incident occurred in 2006 when the Bureau had no history of performing thorough and critical reviews by both the Training Division and Commanders. The failure of the reviews in this case to identify and critique certain performance issues may be partially attributable to this fact as well as the fact that the incident ended without injuries to involved parties.

Delay in the Preparation of the Commander's Review Memorandum

Despite the fact that it offered very little meaningful critique of the incident, the Commander's Review Memorandum took nearly four months to complete. There is no documented explanation for this delay. As we recommended in both of our prior reports, the Bureau should commit to setting and enforcing firm deadlines for Commanders to complete their findings.

May 22, 2007 ◦ Steven Bolen

On May 22, 2007, Portland Police Officers Jon Dalberg and James Habkirk were dispatched to a disturbance call. A neighbor had reported hearing a fight at the townhouse next door. The complainant said that his intoxicated neighbor had rammed his truck into his own garage door in order to get into his house. While the complainant remained on the phone with the emergency operator, he reported that his neighbor was yelling that he was going to kill his girlfriend, who the complainant believed was in the townhouse. The complainant also reported hearing loud banging sounds coming from the neighbor's house. The complainant made a follow up 911 call and informed dispatch that his neighbor possessed a shotgun.

The two officers arrived and Officer Dalberg contacted the complainant. The complainant told the officer that the neighbor owned a shotgun and had threatened to kill the female subject inside. According to the complainant, he and a relative who also lived in the apartment heard what they believed to be the sound of a woman screaming from the next door townhouse. Officers called for an additional unit and Officer Jason Koenig arrived a few minutes later. Prior to Officer Koenig's arrival, the two initial responding officers made an attempt to contact the occupants of the residence by knocking, ringing the doorbell and announcing "police" while at the front door. The officers received no response and heard banging sounds and loud music coming from inside the location.

A responding sergeant broadcast on the radio that he was in transit but approved the on-scene officers making entry into the location if they felt they needed to prior to his arrival. Shortly after Officer Koenig arrived, Officer Dalberg forced open the front door by kicking it. When climbing up the stairs, Officer Dalberg heard a male voice say, "you called the fucking police," and believed that the subject was talking to a female upstairs. As the three officers ascended the stairs, they observed a man later identified as Steven Bolen round an upstairs corner while holding a shotgun. As the barrel of the shotgun appeared to swing toward the officers, Officer Dalberg fired five rounds from his handgun while Officer Koenig fired five rounds from his AR-15 rifle. All three officers immediately retreated from the residence not knowing whether or how badly Mr. Bolen was injured.

The involved officers broadcast shots fired and maintained a perimeter around the residence until relieved by uninvolved cover officers. Officers on scene requested SERT and paramedics. When SERT made entry into the residence 48 minutes

later, they discovered Mr. Bolen deceased on the stairway with a loaded 12-gauge shotgun nearby. Officers searched the residence and found no additional occupants inside. An autopsy of Mr. Bolen found that he had sustained four gunshot wounds to the chest and neck.

Timeline of Investigation and Review

5/22/2007	Date of Incident
8/27/2007	IA investigation began
10/8/2007	IA Investigation completed
5/9/2008	Case forwarded to Commander
6/3/2008	Commander's Findings completed
9/17/2008	Use of Force Review Board
3/10/2009	Date of Chief's letter notifying officers of findings

Analysis/Issues Presented

Reliance on Faulty Information from Civilian Informants

As noted above, the responding officers relied heavily on information provided by the neighbor informants about what may have been transpiring in the Bolen household. That information was incorrect in one hugely significant way, namely that Mr. Bolen was assaulting his girlfriend and threatening to kill her. While responding officers are trained to ask civilian informants about their observations, and should not be dismissive of that information, reliance here on the neighbors' flawed assumptions may have caused the officers to enter a residence that they would not have otherwise entered in an attempt to rescue a nonexistent victim.

Facts developed during the investigation suggest that the officers may have been overly influenced by the neighbors' demands that they rescue the supposed victim. There was no apparent discussion during the incident review process

about whether officers could have employed additional resources or investigative techniques to confirm or disprove the neighbors' statements about a violent crime in progress.[1] For example, the neighbors shared a common wall with the Bolen residence and they claimed they could hear the woman screaming because of their proximity upstairs to where the violence was going on next door. Responding officers could have asked permission to go into the neighbor's residence to see whether they could confirm for themselves the screaming and threats that they did not apparently hear from outside the Bolen residence. If the Bureau had engaged in such analysis and discussion, it may have concluded that the factors presented to the officers did not provide time for further investigation and necessitated a quick entry in order to ensure the safety of a person that was supposedly inside the townhouse. However, the Bureau's failure to identify the issue left a gap in the analytical discussion.

Failure of Officers to Fully Develop an Entry Plan

The two initial responding officers were at the location for approximately seven minutes before being joined by the cover officer and then almost immediately deciding to enter the house. During that time, there was no apparent planning about how to deploy once they entered the location. The Commander's Memorandum noted that the three officers discussed a "loose" plan prior to forcing entry, but all three officers had a slightly different recollection as to the plan. In fact, when Officer Koenig arrived at the location, he thought that his role was to provide long cover across the street and cover the windows of the residence, which likely impacted his decision to arm himself with a rifle.

The Commander recommended that the Bureau use this incident to review and reinforce the importance of developing a plan so that all involved understand what the goal is, how to achieve it, and what is expected of each participating member. For example, it would have been particularly helpful for the initial responding officers to have communicated to Officer Koenig what the plan was going to be as

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[1] As noted above, the officers, to their credit, did see the truck as reported rammed through the garage door, listened to the goings on in the townhouse and did hear loud music which was turned even louder, and banging sounds but did not hear all that the neighbors reported hearing from their townhouse.

[2] In 2012, the Professional Standards Division created an Action Item Database and Standard Operating Procedure that documents and tracks formal recommendations proposed to the Chief of Police by internal and external sources, including recommendations made by the Police Review Board. This new tracking procedure could

he was responding to the location so that he better understood his role and left his rifle in the car.

The Use of Force Review Board recommended that the Bureau create a training video designed to reinforce the need to develop a plan so that all involved understand what the goal is, how to achieve it, and what is expected of each person. The Board further noted that the Commander had already briefed the involved officers regarding the recommendations made at the Review Board but requested that the topics covered with the officers be documented in a memorandum.

Failure to Broadcast Forced Entry

Before the officers forced entry into the Bolen residence they did not broadcast their intent, which is inconsistent with how Bureau officers are trained. The Training Division Review noted that such a broadcast would have communicated the officers' actions to all involved and responding personnel. The Training analysis added that the broadcast would have communicated the increased volatility of the scene and held the dispatch net clear of non-emergency traffic. According to the Use of Force Review Board, their Commander also communicated this issue back to the involved officers; the Board further recommended that the debriefing be documented by the Commander in a memorandum. Further, the Board recommended that the training video that it recommended also reinforce the importance of the Bureau requirement to broadcast when taking action so that responding officers may stay informed.

Failure to Implement Recommendations by the Review Board

As noted above, the Use of Force Review Board recommended that a roll call video be created of this officer-involved shooting. The Board indicated that a video outlining how decisions were made in this incident, the details of the entry, and the subsequent shooting would provide a useful tool for other officers. The Board made specific recommendations regarding the content of the video and the message it was to reinforce. The Board also indicated that the video should emphasize the importance of the Bureau's requirement that dispatch be notified when taking action so that responding officers and others could stay updated about those actions. The then Chief of Police acknowledged receipt of the Board recommendations, including the recommendation to produce a video, indicated that she found them to be sound, and requested that her staff ensure that the recommendations were tracked and resolved.

Despite the Chief's request, the video that had been recommended as the cornerstone of the action plan from the Review Board was never produced. There is also no evidence that the other recommendations by the Board were implemented. For example, when we requested the Bureau to locate the written memorandum that the Commander was requested to prepare with regard to his debrief of the involved officers, no such memorandum could be found. In sum, in this incident, there is no evidence that any of the well-considered recommendations of the Board were ever actually implemented.

As we have previously commented, the PPB has a robust review process for review of officer-involved shootings that identifies issues that are then presented to the Review Board. We have also commented favorably on the Board's careful deliberation and its development and/or adoption of recommendations designed to ensure that Bureau officers are provided follow up training so that they are better prepared to respond to future critical incidents. And we have seen videos that have been produced by the Bureau after officer-involved shootings that present an excellent vehicle for enlightenment and training to its officers. However, if there is no systemic feedback loop ensuring that recommendations coming out of the review process are implemented, well-considered initiatives such as those set out here become stillborn, and the careful review process designed to identify and address issues is for naught. We are hopeful that the system break down evidenced in this case was an historic outlier. However, because the consequences of such a system failure are significant, we urge the Bureau to re-examine its processes to ensure that a robust system currently exists whereby recommendations coming out of its deadly force review process are, in fact, implemented.[2]

The creation of a systematized feedback loop to the Review Board at regular intervals would ensure that the Board recommendations are implemented. Since the Board meets on an ongoing basis, it would be relatively easy for past reviews to be routinely reinserted on its agenda so that progress of past recommendations can be gauged. Such a process has the added benefit to the Board of learning how effective (or not) past recommendations have proven to be in the field. The response of officers to any training videos, the implementation of policy changes,

[2] In 2012, the Professional Standards Division created an Action Item Database and Standard Operating Procedure that documents and tracks formal recommendations proposed to the Chief of Police by internal and external sources, including recommendations made by the Police Review Board. This new tracking procedure could alleviate the issue identified here.

or the response of the involved officers to debriefings are all events that can provide additional insight to the Review Board when it crafts recommendations in the future. Even though the constitution of the Review Board changes from incident to incident, reporting back to the body that is formed to make recommendations on the effectiveness of earlier Board recommendations could be of utility, particularly to recurrent members of the Board.

Recommendation 1: The Bureau should examine its current processes to determine whether there is a sufficiently robust system ensuring that recommendations emanating from its reviews of use of deadly force incidents are implemented.

Recommendation 2: The Bureau should consider adopting protocols where the Police Review Board routinely revisits past reviews to obtain feedback on the implementation and effectiveness of its recommendations.

Decision to Deploy the AR-15 Rifle in Clearing Buildings/Deployment of Police Vehicles

The Training Division Review indicated that it did not recommend using the rifle in clearing buildings because of its 35-inch length. The analysis indicated that once Officer Koenig learned of the urgent need to enter the townhouse his options were to return the rifle to his car which was parked about a block away from the residence, wait for another officer to arrive as cover, or go inside with the other officers, using his rifle. Training concluded that Officer Koenig chose the best option.[3] The Board noted that one corrective action that had already occurred was that a memorandum had been sent to AR-15 rifle operators about the use of the rifle in building clears. The Board recommended that the memorandum should also be forwarded to all sergeants and lieutenants. As with the other

[3] The Commander's Memorandum noted that Officer Koenig might have had difficulty maneuvering with the rifle in the tight stairway area. The Commander recommended that all AR-15 rifles be fitted with proper slings to allow for secure shoulder carry. The Commander noted that had Officer Koenig's rifle been equipped with a sling, he could have transitioned to his handgun as an entry weapon. According to the Commander's Memorandum, the Bureau purchased slings for use by AR-15 operators. The Commander recommended that the new sling be mandatory on all Bureau AR-15 rifles. The Use of Force Board requested that Training Division consider fitting all AR-15 rifles with slings that allow for secure shoulder carry and making it mandatory that the slings be used.

recommendations made by the Review Board, it is unclear whether this recommendation was implemented.

Positioning of the Patrol Cars

The Bureau investigation and the Training Division Review failed to address why Officer Koenig ended up situating his police vehicle a block away from the residence, which then required him having to run a block to the scene carrying the rifle. There is a reference in the investigation that the police car driven by the initial responding officers was positioned one and a half blocks from the Bolen residence because the officers were confused about the location to which they were responding, and that this positioning may have misled Officer Koenig. It is problematic to have both responding vehicles parked so far away, because potentially necessary equipment in the radio cars was not readily available nor did officers have the ability to use the cars as cover if necessary. The positioning of both responding police vehicles and the potential deficit to officer performance was not sufficiently explored during either the investigative or review process.[4]

Decision by Officer to Use Deadly Force Without Acquiring a Sight Picture

Officer Koenig said that as he ascended the stairs, he saw the barrel of a shotgun swing toward the direction of the officers, lost sight of the barrel, and then heard a loud "boom." Officer Koenig said he believed that the individual had shot at the officers. He said that he then stepped to his right to either hit the subject with

[4] After we raised this issue with the Bureau, it replied by indicating that the Training Division concluded it was the correct tactic to stop prior to arriving in front of the address and deploy on foot so as not to be seen. The Bureau further noted that there were other objects and vehicles in the immediate area that the officers could have used for cover. It is informative that the Training Division now has opined that the correct tactic was to deploy on foot, but our major point is that while the issue was evident from the investigation, the Training analysis did not identify the positioning of the police cars during the Bureau's initial review of this issue. Second, while it may well be the case that a deployment on foot was an appropriate response, as noted above, the facts from the investigation suggest that both officers parked at least a block away not because they were carefully considering issues of tactical deployment but because they were confused about the location to which they were deploying. Finally, while there may have been other objects available for cover than police cars, our main point about the distant positioning of their police cars was that a closer positioning of the police cars could have allowed Officer Koenig to more readily return the AR-15 to his police car, and that police cars have other equipment in them, such as first aid equipment, that were not immediately available to the officers because they had parked so far away.

bullets from his rifle or to provide cover fire so that the officers could safely retreat. Officer Koenig said that he did not have a "real good" sight picture of the subject when he fired.

There was no rigorous analysis by the Bureau regarding the desirability of Officer Koenig firing without good target acquisition or his use of cover fire. The issue is particularly relevant here, given the officers' belief that there was a female victim in the apartment and Officer Habkirk's statement that he did not deploy cover fire because he was concerned that he might strike the woman. During interviews of Officer Koenig, neither Detectives nor IA investigators asked him about whether he had any similar concerns when he fired his rifle. Nor was there sufficient analysis about the decision by the Bureau's reviewers.[5]

Decision to Vacate the Residence After the Officer-Involved Shooting

Before deciding to enter the location, the officers were informed that the individual was armed with a shotgun, but decided to place themselves at considerable risk because of their belief that he was violently assaulting a female victim. After engaging the armed individual and firing ten rounds at him, they tactically retreated, left the residence, redeployed across the street and asked for SERT to respond. Officer Dalberg said that after the shooting, he took cover across the street from the Bolen residence where he could no longer see the front door of the residence. Forty-eight minutes later, SERT entered the residence, located Mr. Bolen, and found him deceased.

Neither the Training Analysis, the Commander's Memorandum, nor the Review Board discussed the degree to which the calculus changed after the officers vacated the residence leaving a supposed female victim inside the location with a subject who had pointed a shotgun and perhaps fired at the officers. Officer Dalberg said that after the shooting, he believed but was not sure that he had hit Mr. Bolen. During the entry, officers observed blood in the entryway and heard the person apparently complain to the assumed victim about her calling the police. Both of these observations and assumptions increased their belief that there was a female victim in dire straits inside the location. Thus, after the shooting, the officers were still presented with facts similar to those that caused them to enter the residence initially, plus additional facts that supported their beliefs; namely, a

[5] This is not intended to pass judgment on the appropriateness of Officer Koenig's use of deadly force, considering the circumstances. The point here is that the failure to develop a "sight picture" or the use of cover fire were not carefully assessed in the Bureau's initial Training Analysis.

known armed person whose physical condition was unknown and a female victim who was likely injured and potentially vulnerable to further assaultive behavior or worse by the individual. Nonetheless, the involved officers, responding sergeants, and uninvolved officers chose to wait for SERT to deploy rather than attempt to reenter the location in order to complete the mission of rescuing the victim.

The Bureau investigation did not ask any of the responding officers about why they chose to abandon their rescue attempt until SERT arrived nor is there any analysis regarding this subsequent decision. The Bureau may have concluded that officers made a sound tactical decision to withdraw and wait for SERT after their initial encounter, given that they now knew the suspect was in actual possession of a shotgun, had pointed it at the officers and may have fired it. When the Bureau initially reviewed this shooting, however, it did not consider this post-shooting decision by officers. A robust review of an officer-involved shooting should explore and analyze not only the shooting decision itself, but also other critical decisions that precede and occur after the deadly force incident

Quality of Investigation and Review

Inordinate Delays in the Investigative and Review Process

Records show that the review process of this May 2007 officer-involved shooting concluded in March 2009 when the involved officers were informed by the then Chief of Police that she had found their use of deadly force and entry in the location to be consistent with Bureau policy and guidelines. There are two particularly noteworthy gaps of apparent non-activity in the twenty-two month investigative and review timeline. First, records indicate that after the Internal Affairs investigation was completed, it took seven months before the investigation was forwarded to the officers' Commander for his review. At the use of force review board hearing, the Portland Police Officer's Association representative registered appropriate concern about the lack of timeliness of the investigative and review process. That concern apparently fell on deaf ears, because eight more months transpired after the Use of Force Review Board concluded before the Chief issued her findings letter to the involved officers.

In prior reports, we have expressed concern about the inordinate delay in the investigative and review process in some cases. The Bolen shooting is another example of remarkable delays in the process. In response to our concerns and

under pressure from the Department of Justice, the Bureau has indicated a resolve toward ensuring a more timely investigation and review of these critical incidents. As a result, we are hopeful that the delay noted in this incident will prove to be a relic of past issues that have to date since been resolved and improved.

Leading Questions by East County Major Crimes Task Force

As we and others have commented in prior reviews of officer-involved shootings, the designation of non-Portland Police Bureau officers to the interviews of involved officers has resulted in non-optimal interviews. Again, in this case, the involvement of a non-Portland detective in the interview process resulted in extensive leading questions apparently designed to produce a record that there was an adequate justification for the shooting. The use of leading questions in this context potentially opens the investigation to criticism that the investigating detectives have predetermined the outcome. We renew our concern about the participation of the Task Force in these sensitive interviews.

To the degree that the Bureau uses the East County Major Crimes Task Force to provide external perspectives on the Bureau's officer-involved shooting investigations in an attempt to legitimize those investigations, its value is diminished when the work of those investigators potentially casts doubt on the objectivity of the investigation.

Recommendation 3: The Bureau should again consider whether it is beneficial to the interests of the City to have the East County Major Crimes Task Force involved in investigations of PPB officer-involved shootings.

October 5, 2007 ◦ Jeffrey Turpin

In the early morning hours of October 5, 2007, officers from the Scappoose and St. Helens Police Departments were dispatched to a prowler call. The report from dispatch was that the informant had heard a gunshot and that the prowler was armed with a handgun. When officers arrived, they met an individual later identified as Jeffrey Turpin walking up and down the sidewalk. According to responding officers, Mr. Turpin appeared to be agitated and was talking to himself.

The initial responding Scappoose PD officer indicated that he observed Mr. Turpin in possession of a handgun. According to the police report, Mr. Turpin pulled the gun out from under a flag that he had draped over his shoulders and showed it to the officer. The officer was able to persuade Mr. Turpin to place the gun on the ground and Turpin stepped approximately five to eight feet away. Mr. Turpin refused to move farther away from the gun despite instructions from officers.

The Scappoose officer continued to talk to Mr. Turpin who advised him that ten people were chasing him whom he thought were police officers. As the officer continued to talk with Mr. Turpin, he returned to where he had placed the gun, retrieved it, and held it to his head. Mr. Turpin then walked toward the officer while yelling "you are going to shoot me." One responding officer estimated that Mr. Turpin got within ten feet of the responding officers. Mr. Turpin then changed direction and walked up a nearby residential driveway.

According to Scappoose police reports, Mr. Turpin yelled at officers and said "back off you fuckers or someone is going to get shot." Mr. Turpin walked up to the residence entrance and pounded on the door with his gun pointed at his head. Mr. Turpin then walked away from the front door with his gun still pointed at his head. Mr. Turpin returned to the front door and pounded on it a second time.

The door that Mr. Turpin pounded on was the residence of PPB Sergeant Greg Stewart. When Sergeant Stewart was informed that a man with a gun was outside his residence, he directed his wife and two children into the downstairs utility room and retrieved his weapon. He was in telephone contact with dispatch personnel handling the incident, who instructed him to evacuate the residence with his family through the back door. Sergeant Stewart asked if there was an evacuation plan. The dispatcher told Stewart that the officers had provided no further guidance. Stewart then informed the dispatcher that he was going to take

his family out the back door of the residence. The dispatcher acknowledged Stewart's plan. During this conversation, the dispatcher instructed Sergeant Stewart to get his family down, because the subject in front of Stewart's house had the firearm up to his head again. Stewart complied. Stewart was asked by the dispatcher if he had a police radio in his possession in order to monitor the ongoing police event. Sergeant Stewart informed the dispatcher that he did not.

Shortly thereafter, Sergeant Stewart informed the dispatcher that he would have to put the phone down to take his family out the back of his residence. The dispatcher acknowledged the plan and Stewart and his family left the residence. Sergeant Stewart said that from outside the corner of the house, he could not see the whereabouts of the armed subject and no officers were in view or present to provide Stewart and his family protection or directions. Sergeant Stewart said that he realized that he was placing his family in a more dangerous position than they had been in while they were inside the house, and made an informed decision to return back inside.

Sergeant Stewart, upon reentering his house, intended to call dispatch but accidentally called his neighbor. According to Sergeant Stewart, he realized the armed subject had re-approached his front door and he did not have time to call dispatch back.

After Mr. Turpin approached the door a second time, Sergeant Stewart, who had positioned himself in the front stairwell of his residence, fired four rounds through the door and adjacent window of the residence, striking Mr. Turpin with two of the rounds in the neck and chest. Mr. Turpin was eventually pronounced deceased at the scene.

Timeline of Investigation and Review

10/5/2007	Date of Incident
5/30/2008	IA Investigation completed
6/3/2008	Commander's Findings completed
1/21/2009	Use of Force Review Board
7/27/2009	Memorandum Recommending Convening of Working Group
11/30/2009	Work Group Response to Use of Force Review Board Recommendations

Analysis/Issues Presented

Failure to Retrieve Ballistic Vest

According to the account of the incident, when Sergeant Stewart retrieved his gun from an upstairs closet, his ballistic vest was located next to the gun yet he failed to consider wearing the vest when dealing with the armed individual. Instead, Sergeant Stewart put on his young son's vest, which had no ballistic qualities. When Sergeant Stewart returned to the closet to retrieve a second magazine, he still did not retrieve his ballistic vest. Sergeant Stewart attributed this oversight to "poor thinking." However, in the reviews of the event by the Commander, the Training Division Review, or the Use of Force Review Board, this tactical shortcoming was not considered or discussed. As a result, no recommendations were devised or considered about the need to perform and equip oneself consistent with principles of officer safety.

Criticism of Other Agency's Response

While the PPB review process asserts that it did not evaluate the "actions" or "non-actions" of the Scappoose PD response, the analysis describes that response, implying a belief that the on duty officers should have shot the armed person and that their failure to do so left that responsibility to the off-duty PPB sergeant.

There was no apparent attempt by PPB IA investigators to interview the Scappoose on-duty officers and inquire of them about their decision not to use deadly force against Mr. Turpin. However, the Commander's Memorandum recommended that the responding police departments be contacted and that PPB offer to "assist" them in conducting a review of the police tactics deployed by their officers during the incident. Similarly, the Training analysis recommends that PPB have a conversation with Scappoose police command regarding their training and possible learning points from this incident. There is no evidence that there ever was a follow up discussion or briefing with the responding agencies, despite these recommendations.

Finding that Suspect "Forced" Use of Deadly Force

An integral part of PPB's current review process is the Commander's Memorandum, in which the Commander who has supervisory responsibility over the involved officer evaluates the conduct of the officer. With regard to this shooting, the Commander found that Sergeant Stewart was justified in using deadly force and acted within policy when the actions of Mr. Turpin "forced" Sergeant Stewart to defend his life and the lives of his family members. The PPB Use of Force Review Board also adopted this mind set when it came to the conclusion that Sergeant Stewart was "forced" into a situation through no fault of his own.

The essence of tactical training provided to police officers is to ensure that officers take the lead on impacting outcomes and not allow the suspect to "force" the action. While a police officer must certainly be mindful of the potential threat an erratically performing armed person poses, it is paramount that the officer use that training to ensure that the outcome ends on the police officer's terms, ideally short of a deadly force incident. Moreover, police officers, by their very responsibilities, will be continually "forced" into situations that are not ideal and must use their training and skills to end encounters optimally. While not every use of deadly force can be avoided, any suggestion from supervisors that the suspect was in control and the police officer was "forced" to respond on the suspect's terms insufficiently credits a police officer's ability and training to influence the result and lessens the responsibility of the involved officer to do just that. While trained officers are unable to "ensure" the outcome of events, use of their tactical training to gain positions of advantage can "ensure" that to the degree possible, the police officer, not the subject, dictates the outcome. As PPB's leaders continue to shape the culture and orientation of its supervisors in

considering deadly force incidents, it should be mindful of this tenet of progressive policing and attempt to inculcate this mindset among its executive team.

Sergeant's Decision Not to Warn Mr. Turpin

PPB's directive on deadly force (1010.10) states that members may use deadly force to protect themselves or others from what they reasonably believe to be an immediate threat of death or serious physical injury and "if feasible, some warning has been given." The Commander's Memorandum concluded that no warning was feasible because Sergeant Stewart made a "split second" decision to use deadly force, he was not behind hard cover (standing exposed on his open stairwell), he was involved in a dynamic highly fluid situation involving an armed "desperate" suspect who made statements to officers that "someone was going to get shot" and any delay in firing could have placed Sergeant Stewart, other officers, and members of his family in jeopardy of being shot by Mr. Turpin.

During the subsequent meeting of the Use of Force Review Board, the Commander's conclusion was apparently accepted without scrutiny, as there is no reference in the Board's findings to the failure to warn Mr. Turpin. However, the Commander's conclusion was based on a not entirely accurate depiction of Sergeant Stewart's mindset. First, there is no evidence in the investigative record that Sergeant Stewart knew at the time he decided to shoot that Mr. Turpin had made any threatening statements to the officers outside. Moreover, the analysis fails to recognize that while Sergeant Stewart was not behind "hard cover," there was a front door between him and Mr. Turpin and it was Sergeant Stewart's decision to place himself in that position before using deadly force.

The Commander's analysis also fails to acknowledge the rationale behind the Directive's dictate that police officers provide warnings before using deadly force when feasible. Most paramount, providing a warning gives the individual an opportunity to stop engaging in the threatening behavior that has caused the officer to consider using deadly force. If the officer can neutralize the threat through a warning, he or she will not need to use deadly force.

This particular incident raises additional issues regarding Sergeant Stewart's decision not to warn Mr. Turpin prior to using deadly force that were apparently not considered during the internal review process. First, when Mr. Turpin began banging on the residence door, he had no idea that on the other side of the door was an armed off-duty police officer about to shoot at him through the door and

window, an unorthodox and likely unanticipated use of deadly force. Second, it is unclear to what degree Sergeant Stewart would have been disadvantaged in this encounter if he had paused slightly to alert Mr. Turpin that he was a police officer prepared to fire his weapon. Given the potential that such a warning could have led to a different result in this case, the PPB internal review process in this case insufficiently evaluated Sergeant Stewart's decision to shoot without warning.[6]

Use of Force Review Board Recommendations

On January 21, 2009, almost 21 months after the shooting, the Use of Force Review Board was finally convened and reviewed the incident. The Board indicated that they were "impressed" with Sergeant Stewart's judgment and thoughtfulness in a very stressful situation. The Board found no policy violations and unanimously found Sergeant Stewart's use of deadly force to be in policy. On July 27, 2009, a memorandum was prepared by the Board's chair to then Chief of Police Rosanne Sizer documenting this finding. The Board also recommended that the Bureau convene a work group to evaluate policies governing officers' off-duty uses of force and to make recommendations regarding what type of processes and reviews should occur in any future similar cases.

It is unclear why it took the Use of Force Review Board over six months to document their findings and offer recommendations. Nonetheless, upon receipt of the memorandum, Chief Sizer convened the working group. As set out in the Review Board's memorandum, the group consisted exclusively of members of the

[6] In subsequent correspondence with OIR Group, the Bureau maintains that it was not practical for Sergeant Stewart to provide Mr. Turpin with a verbal warning because he was outside and actively being confronted by uniform officers. The Bureau also asserts that there was no indication that Mr. Turpin would have changed his behavior as a result of a warning coming from inside the residence since he had not stopped engaging in threatening behavior thus far, despite the handling agencies' attempts to get him to do so. The Bureau maintains that providing Mr. Turpin with a verbal warning from inside would have potentially placed Sergeant Stewart at risk, as Mr. Turpin would have then learned that there was a person inside. The Bureau further alleges that if Mr. Turpin heard a verbal warning, he could have shot through the door at the voice since his behavior had not been rational. Finally, the Bureau concludes that if the subject's goal was one of "suicide by cop," then forcing the issue with another police officer inside the home would have furthered that goal. While we understand and respect the Bureau's perspectives, whether Sergeant Stewart should have given a warning prior to his use of deadly force in this case is an issue that should have been addressed more fully during the Bureau's review of this case.

Portland Police Bureau. Neither the IPR nor any non-PPB members of the Use of Force Review Board were included.

The working group was to consider the following issues that had been recommended by the Use of Force Review Board:

- Is it required that the member give a warning before using force?
- If a member uses deadly force, must the member's actions be consistent with PPB training principles and doctrine?
- Is the member prohibited from firing a warning shot?
- If a member shoots someone while defending himself, is the member required to continually monitor and give aid to the person?
- If a member uses deadly force inside or outside of city limits, is the member required to complete a FDCR or other PPB report?
- Are detectives in charge of investigating all deadly force incidents, including off duty?
- Are communication restriction orders issued when an off duty member uses deadly force inside or outside of city limits?
- Are the rules of the Bureau's release of information applicable?
- Do the Bureau's rules regarding shooting at vehicles or injured or dangerous animals apply off duty?
- Are off duty officers required to self-report negligent or unintentional discharges of firearms?
- What is the "official authority" as used in the definition of police action?
- Any other issues the work group identifies.

Four months later, a memorandum was prepared setting out the working group's recommendations. The group first noted that it had decided that whether officers would be considered on-duty or off-duty hinged entirely on whether officers identified themselves as police officers.[7]

[7] The working group concluded that the distinction it recommended between on-duty and off-duty shootings would benefit the officer involved as well as the Bureau as it related to "legal representation and liability." However, there were apparently no attorneys or experts on civil liability in the working group. More importantly, principles of accountability, officer safety, tactics, polices, and training intended to reduce the likelihood of officers becoming involved in deadly force incidents, either on or off duty should trump any interest the City might have in reducing "liability" for them.

While such a bright-line rule has some appeal because of its certainty, for this one factor to be determinative does not logically hold together under hypothetical scenarios. For example, if an off-duty police officer is upset when another motorist cuts him off and then follows the motorist in his personal car using flashing lights, uses his personal cell phone to call PPB for assistance, travels at a high level of speed as the motorist tries to elude him, gets in a traffic accident with the motorist, and then shoots the motorist as he alerts from the car, one could not conclude that because the officer did not announce himself as a police officer, he should be subject to the more lax standards envisioned for off-duty incidents. Moreover, an unintended consequence for such a rule would be to create disincentives for officers who are off-duty to announce themselves as police officers and thus be subject to the more stringent rules when they do so. Most importantly, the Bureau's determination about whether a police officer is on or off duty should mimic the public's understanding of such; a police officer who is not working his assigned shift is "off-duty" whether the officer announces that he is a police officer or not.[8]

The work group then determined that off-duty members were not required to follow the Bureau's Deadly Force directive requiring that warnings be provided, when feasible, before using deadly force. Because the definition adopted by the work group categorizes those officers who give warnings as being on-duty, under the calculus considered by the work group, an officer has free reign to decide whether to provide warnings and if officers do so, they will automatically find their conduct being assessed by stricter policies. The work group's decision to allow officer's complete discretion on whether to give warnings when they are not working their shifts essentially eviscerates the warning requirement for those officers and the Constitutional policing principles behind it. The better approach is that practiced by similarly situated police agencies – all officers, on or off duty, should be held to the standards set forth in the agencies' policies and training, with the understanding that off-duty officers may not have available all of the tools and safety equipment they have while on-duty and therefore might be constrained in some aspect of their performance.

[8] The working group believed whether the member used a personally owned weapon or a duty weapon was another important distinction. While many members of the working group surmised that the use of a personally owned weapon warranted "less scrutiny" by the Bureau of the incident, the group asked for research on this question. There is no evidence that such research was actually undertaken or completed.

The work group further determined that if an off-duty officer's actions are "intentional" the officer did not necessarily have to conform to PPB training, principles, or doctrine. It is unclear what is meant by an "intentional" act, but the memorandum distinguishes such actions from "reckless and negligent" acts. Again, the work group's advisement is that if an off-duty officer is intent on using deadly force, he or she will not need to conform to rules and doctrine they are required to follow when they are on duty, essentially giving officers a free pass with regard to their actions. Again, the better approach is to expect that officers perform consistently with the Bureau's standards and training even when off duty. Moreover, the Bureau should train its officers to recognize that they are disadvantaged when off duty and should avoid getting into tactical situations because of the limitations. The public expects that officers will perform consistently with their training and Bureau rules, regardless if they are on duty or off duty. For the Bureau to afford free reign in determining which, if any, rules to follow while off duty is to undermine officer performance and accountability with regard to these incidents.

The work group found that despite the Bureau's prohibition on warning shots, there should be an exception for warning shots if the officer is off duty. Under the work group's logic, since off-duty officers are disadvantaged by their off-duty status, they should be allowed to use tactics that the Bureau otherwise finds to be unsafe for officers policing the Portland community. Similar logic was employed by the work group in determining that the Bureau's restrictions on shooting at vehicles should not apply for off-duty shootings since off-duty officers may not have all the tools normally available to respond to the threat. The logic advanced by the work group is extremely misguided and inconsistent with principles of Constitutional policing. Rather than allow off-duty officers to deploy a technique that has been judged unsafe and banned by the Bureau for their on-duty rank and file, the preferable approach is to continue to advise officers that because of the tactical disadvantages they have when they are off duty, they should avoid involving themselves in confrontations where they would even need to consider such inadvisable techniques.

The working group similarly recommended that officers who were off duty and shot an individual should be excused from the Bureau's requirements to subsequently monitor the individual and provide aid. The rationale for elimination of this requirement is that an officer would not have the tactical equipment necessary to either monitor the individual or provide first aid. Again, rather than excuse entirely an off-duty officer from rendering first aid, the better

guidance is to advise officers involved in off-duty incidents about the interest in ensuring that persons downed by their gunfire are monitored and receive first aid as quickly as practicable, considering the constraints that the off-duty officer has. Officers should be advised of their important role in contacting rescue personnel and on-duty law enforcement so that these responsibilities can be readily transferred to better-equipped individuals.

Portland officers involved in shootings are routinely given a communication restriction order instructing them not to discuss the incident during the pendency of the investigation. In the Turpin shooting, such a communication restriction was not given to Sergeant Stewart, perhaps, in part explaining why there was an apparent "tactical debriefing" between him, another Bureau detective, and unknown additional third parties prior to his interview with Internal Affairs. The work group concluded that the Bureau did not have authority to issue a communication restriction order when an officer uses deadly force off duty unless an IA investigation is opened. The rationale behind the communication restriction order for on-duty shootings – preserving the integrity of the investigation by avoiding witness contamination and influence – applies equally in off-duty shootings. The Bureau should ensure that such restrictions apply to all officers involved in deadly force incident, even if it requires the formal opening of an Internal Affairs investigation.

Recommendation 4: If there is uncertainty regarding whether PPB can issues communication restriction orders to officers involved in off-duty shooting incidents unless an Internal Affairs investigation is opened, the Bureau should revise its policies so that communication restriction orders are issued in all shootings involving PPB personnel, regardless of whether the shooting is on or off duty.

The most concerning recommendation made by the work group was for the Bureau to provide the Chief of Police the discretion not to convene a Use of Force Review Board for off-duty shootings such as the Turpin matter. The work group's rationale was that tactically there might not be anything the Bureau could learn from such shootings. The work group further opined that if the investigation "clears" the officer of any wrongdoing, there might not be any benefit to the officer involved or the Bureau to convene a Review Board. The work group wrote that if the deadly force was considered justified, then having a Review Board solely to satisfy the requirement of the Bureau's directive would be counterproductive.

This recommendation and the rationale behind it are directly contrary to progressive police practices and the Bureau's history of close and careful review of critical incidents. For years, the Bureau has recognized that each officer-involved shooting presents a potential learning experience for individual officers and the organization as a whole. Whether an officer is "cleared" of any wrongdoing should not end the discussion about what corrective actions can properly be identified and implemented through the review process. As delineated in this report, there were issues and the potential for learning coming out of the Turpin shooting that could have improved the Bureau, had the internal investigation been more exacting and the review process been more robust and critical. For a working group to suggest that, at least for some off-duty shootings, there is no potential for learning indicates that some members of the organization have yet to recognize the inherent value of the Bureau's review processes.

It is unclear what happened to the working group's final recommendations. Fortunately, it appears the Bureau did not implement them. While we are pleased to learn that the ill-conceived ideas went nowhere, it would be preferable to know whether the proposals had been carefully considered by command staff and rejected, or whether they merely fell through the cracks as a result of inattention, as did those recommendations emanating from the Bolen shooting.

Quality of Investigation and Review

The initial investigation of this off-duty incident was conducted by the Oregon State Police in conjunction with the Scappoose Police Department.[9] PPB's follow up internal investigation was limited to an administrative interview of Sergeant Stewart and interviews of two other PPB personnel.

Investigative and Review Delays

The brief PPB Internal Affairs investigation was not completed until over seven months after the incident. It took another five months for the Commander's Memorandum to be completed. And it was three months later that the Use of Force Board met and issued their findings. As we have said elsewhere in this report and in previous reports, the length of time the PPB takes for its officer-

[9] As part of its review, the Oregon State Police prepared an animated recreation of the incident. The "recreation" is not entirely faithful to the evidence and clearly intended to portray the shooting in a light sympathetic to Sergeant Stewart.

involved shooting investigation and review process to be completed too often has fallen well outside accepted industry standards.

No Apparent Forensic Analysis of the Front Door of the Residence

According to Sergeant Stewart's account of the incident, one of his concerns was that Mr. Turpin pounded on the door with such ferocity that he was concerned that the door would give way and he would find himself in a disadvantaged encounter with an armed individual. The only evidence contained in the investigative reports about the force that Mr. Turpin used on the door was derived from witness statements. There is no analysis in the investigative reports about the sturdiness of the front door in question and whether there was any evidence of the door being damaged as a result of Mr. Turpin's repeated pounding on the door. Such analysis could have assisted decision makers on the degree to which Sergeant Stewart's concern about the door being breached by Mr. Turpin had objective validity.[10]

Briefing with Sergeant and PPB Prior to IA Interview

There is reference in the report to an apparent briefing at Sergeant Stewart's neighbor's house (a Bureau detective) prior to Sergeant Stewart being interviewed by IA. Sergeant Stewart's neighbor was in contact with Sergeant Stewart prior to the shooting. Also, in his interview, Sergeant Stewart gives some indication that he already knew about forensic results regarding where bullets struck Mr. Turpin, again suggesting that investigative information was provided to the shooting officer prior to his administrative interview. It is anathema to basic investigative practices to permit briefings among witnesses or to provide witnesses forensic information prior to the completion of the fact gathering process. Neither the

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[10] The Bureau maintains that objective witnesses from other police agencies provided enough good evidence of the reasonableness of Sergeant Stewart's concerns and that a post incident forensic analysis of the door would not have provided Stewart with the information he needed to know prior to the shooting. While we acknowledge that there was evidence from Sergeant Stewart and police witnesses' statements about the subject's actions toward the door, as in any critical incident investigation, there can never be "too much" evidence, and a forensic examination that found damage to Sergeant Stewart's door would have helped confirm Sergeant Stewart's concern that the subject might have breached the door. With regard to the Bureau's second argument, it misunderstands the point; of course the forensic analysis would not have provided Sergeant Stewart any additional information prior to the shooting; the forensic analysis would have gone to helping establish through measurable evidence the degree to which the subject's actions could have potentially breached the front door.

Commander's Memorandum, the Training Division Review, nor the Use of Force Review Board commented on the apparent breach of this universal principle.

Training Division Review Departure from Dispassionate Analysis

The Training Division Review of the shooting has no criticism whatsoever of Sergeant Stewart's use of deadly force or tactical response and neglects to discuss the issues elucidated above. The analysis concludes by noting that the incident was a "tragic event" for Sergeant Stewart and his family. While this undoubtedly was a traumatic event for the Stewart family, the analysis does not mention the tragedy for Mr. Turpin and his family. This type of unbalanced comment can be taken by some members of the community as evidence of a lack of objectivity and dispassion by supervisors assigned to objectively assess the incident. Bureau command staff should continue to be mindful of identifying such prose and recognizing that it might be a potential indicator that the reviewer assigned to conduct the analysis may not have the orientation necessary to conduct a balanced and objective tactical review.

May 15, 2008 ◦ Derek Coady

On May 15, 2008, members of the Portland Police Bureau's Gang Enforcement Team (GET) were assisting FBI agents and members of the Metro Gang Task Force in the execution of a federal warrant at a residence as part of a 15-warrant narcotics operation. At about 5:40 a.m. officers knocked and announced their presence, then breached the front door and found Mrs. Coady in the house. Her husband, Derek Coady, was the one named in the arrest and search warrant. She told them he was in the shop outside.

Task force officers went to the largest of three sheds located behind the house and announced their presence. There was no response. An officer pulled open the large double doors at the front of the shop. Mr. Coady was sitting on the floor cross-legged near the back of the shop, facing the front of the shop with the barrel of a handgun in his mouth. Officer Russ Corno and a Detective of the Vancouver Police Department alerted the officers around them that the individual had a gun in his mouth. The Vancouver Detective said to Coady, "Don't do it. It's not that bad." Officer Corno also ordered him to put the gun down. Mr. Coady did not respond; he kept the gun in his mouth. After a minute or two, during which the Vancouver Detective continued to try to persuade Coady to cooperate and not kill himself, he suddenly leaned over and rolled toward the front of a Hummer vehicle which was parked facing into the back of the shop and started to disappear from view. He kept the gun in his mouth as long as he was visible. When Mr. Coady moved to get behind the Hummer, Officer Corno went to a kneeling position and fired a shot at him as he rounded the front tire of the vehicle. Officer Corno paused for a second, and then fired another round under the vehicle, attempting to "skip" the round off the concrete floor at the individual.

Officer Corno then dropped down to a prone position so that he could see under the Hummer. As he moved to do so, he heard one shot coming from the direction of Mr. Coady. He looked across the floor and saw that Mr. Coady appeared to be lying down, although he could only see his legs, and heard gasping and labored breathing.

The officers could not determine whether Mr. Coady was dead or wounded. They moved out, contained the shed, and activated SERT. When SERT officers arrived less than an hour later they formed a plan to approach Mr. Coady with ballistic shields. They found Mr. Coady lying on his back behind the Hummer with an apparent gunshot wound to the head. He was unresponsive, not breathing and appeared to be deceased. He had a .45 caliber semi-automatic handgun lying

beside his right torso. A paramedic pronounced him dead approximately 84 minutes after the shots were fired.

Detectives examining the scene after the incident found a spent bullet in a torn plastic bag with some rags close to Mr. Coady's head. During the post mortem medical examination, a spent .45 caliber shell casing was found in the sleeve of the sweatshirt Mr. Coady was wearing. There was a single gunshot wound to Mr. Coady – the entry was in the upper palate of his mouth and the exit was at the crown of the head. The medical examiner concluded that the manner of death was suicide. The toxicological examination detected methamphetamine, amphetamine and cocaine.

Detectives noticed two video cameras on the corner eave of the house that had not been detected during the prior reconnaissance of the warrant location. The cameras pointed toward the front gate and the yard area. In the shop where Mr. Coady shot himself, detectives found a video monitor that displayed the two video images taken by cameras mounted on the house. They determined that the cameras were motion activated video cameras with audio as well. The system was direct feed only and did not record video.

When interviewed after the shooting, Mrs. Coady asked if Mr. Coady had killed himself and stated that Mr. Coady had told her in the past that he would never go back to jail. She said he had talked of suicide previously. She stated that her husband had noticed at 3:00 a.m. that morning that the front gate across their driveway was open, expressed concern about it and suggested she call the police. She did not do so.

Timeline of Investigation and Review

5/15/2008	Date of Incident
7/24/2008	Detectives' Investigation completed
12/19/2008	IA Investigation completed
4/10/2009	Commander's Findings completed
7/1/2009	Use of Force Review Board

Analysis/Issues Presented

Supervisor's Actions Likely Alerted the Suspect and Potentially Compromised the Execution of the Search Warrant

The team serving the search warrant in this case included members with broad experience in planned or high risk operations, including gang suppression and narcotics officers as well as four members who were also designated as SERT officers. Because it was a multi-agency team, however, clear and reliable supervision was all the more vital. The sergeant who led the team in this case made a questionable decision to open the gate across the suspect residence driveway and then did not share this piece of information with his team. This seemingly small detail had been discussed by the supervising lieutenant and three sergeants, including the team leader, two days before the operation. During that discussion, they recognized that the layout of the residence and outbuildings on a relatively large piece of land with a long driveway closed off by a gate presented elevated risk. In fact, they originally recommended that SERT serve the warrant itself, but eventually agreed that the GET team would serve the warrant directly if the team encountered an open gate. However, the plan was that, if the gate was found closed, the team would instead wait for the individual to leave the premises before arresting him and serve the warrant. Due to concern about accidentally alerting Mr. Coady to the presence of police, the lieutenant and three sergeants agreed not to send anyone to check on the status of the gate prior to the time the warrant was served.

Despite this decision, the team sergeant nevertheless went by the house at 3:30 a.m., walked up to the gate, found it closed and opened it, then went to the search warrant briefing and failed to alert his team to these facts. The sergeant had told a surveillance detective and one officer participating in the operation that he had opened the gate. However, the participating officer did not alert the rest of the team or raise the issue at the briefing. The GET team went to the location, found the gate open, and proceeded to serve the warrant directly per the prior arrangement. Unknown to them, Coady was up and around at about the time that the sergeant had gone by the house and had in fact noticed the gate had been opened. He alerted his wife that they might have an intruder.

As the Bureau's Training Review enumerates in detail, this independent action on the part of the team sergeant put the surprise element of the operation in jeopardy, stimulated Mr. Coady to move around the compound (he was observed doing so by a surveillance officer later), and raised the threat level of an already relatively

high risk warrant service. While the earlier reconnaissance's failure to spot the video cameras mounted on the roof was inadvertent, the sergeant's actions was in direct contravention of the principles of officer safety that had been the organizing tenet of the original plan.

The Shooting Officer's Tactics

Officer Corno described his fear that the individual was trying to seek cover in order to fire upon the officer or other officers. Officer Corno felt that the sudden defensive actions taken by Mr. Coady and a change of mood that he perceived in him justified his use of lethal force. He said that he wanted to stop Coady from getting to effective cover "or at least…stop him from popping back out once he gets behind that tire and taking shots at Officer [Vancouver detective] and myself or other officers before we have an opportunity to get to hard cover." He believed that his bullets had failed to strike Mr. Coady and yet he dropped to the ground to look under the car rather than seek cover outside the shed.

The fundamental question raised by the use of lethal force in these circumstances is, in the words of the Bureau's policy on use of deadly physical force, whether the officer "reasonably believe[d] [Mr. Coady] to be an immediate threat of death or serious physical injury" to himself or others. The officer inferred an intent or plan on the part of Mr. Coady and made a quick decision that his actions required or justified the shooting. He stated that he felt he had no other force options at the moment.

Despite the central question of reasonableness, the investigations of the incident and the interviews of Officer Corno by Detectives and by Internal Affairs yield very little information about the officer's thinking or the basis for his perception that Mr. Coady was about to attack. He stated, in sum, that Mr. Coady's failure to surrender, the fact that he began to look at the positions of other officers in the group, and his sudden movement toward cover conveyed an impression of an immediate threat. He was asked whether he considered using the less lethal weapons that were available among his group of officers, but he was not asked about the other main tactical option – repositioning to a safer location. Officer Corno and other officers present at the shed recognized immediately that Mr. Coady was creating a barricade situation when he refused to put down the gun and moved behind the Hummer, but it is not clear whether they considered one of the standard responses to a barricade situation, that is move to cover and await the arrival of SERT. The decisions made during the urgency of the moment may not have included the deliberate weighing of each tactical option, but it was important

for the Bureau to consider whether the option to tactically reposition and call in SERT was feasible or practical.

The absence of available effective cover was a factor affecting the decisions of Officer Corno. This should have been discussed among the members of the team who planned to open up the shed, especially since they had good reason to believe Mr. Coady was inside, had guns available to him, and was aware of their presence. Officer Corno mentioned the fact that the thin metal walls of the shed would not have provided a real barrier to Mr. Coady's gunfire for he and his colleagues, but there is no exploration of the concept of concealment, which the shed walls could certainly have provided.

Recommendation 5: The Bureau should ensure that policy and training convey a clear message that the option to tactically reposition, contain and call in SERT is often the preferable one when a situation transitions to a potential barricade.

Delayed Opportunity to Seek Medical Attention for the Downed Individual

When Mr. Coady fired a shot and appeared to have stopped moving behind the vehicle in the garage, it was unclear to the officers present whether he had shot himself or had fired in their direction. Therefore, as Training deemed it, the "situation turned into an armed, barricaded felon," which is a mandatory SERT call out. SERT arrived and approached Mr. Coady with ballistic shields approximately an hour and 15 minutes after shots were fired, a reasonable time from a logistical point of view but a long time to delay administering medical care to a probable wounded person. This issue relates back to the original decision not to have SERT serve this possibly high–risk warrant; if SERT had been on scene, it would have increased the capacity to deliver more rapid medical attention. When the Bureau determines whether an operation should be a SERT handle, one factor in favor of assigning the matter to SERT is the ability of the team to deliver a more rapid medical response.

Quality of Investigation and Review

Some Police Witnesses Not Interviewed by Detectives

Detectives interviewed most of the involved officers soon after the incident, pursuant to PPB protocols, but they did not interview FBI agents who are referenced in the descriptions of the search/arrest warrant team. Those agents may have been peripheral to the events in this incident; they may have been reluctant to participate in the investigation; or they may have been simply logistically difficult to interview. There is no information in the investigation that indicates whether such interviews were determined to be not important, not feasible, or not practicable. Some explanation for the absence of FBI witnesses should have been included so that reviewers could understand investigators' rationale for failing to interview all of the other on scene law enforcement personnel.

Recommendation 6: As part of its internal investigative protocols, Bureau investigators should strive to interview all witness officers from other agencies; if such interviews prove not feasible the investigation should indicate why.

Internal Affairs Division Report

Internal investigations of all types can suffer from too narrow a focus on the specified subject of the investigation or, in the case of officer-involved shootings, on the actions and judgment of the shooter officer. The Internal Affairs report in this case was wide-ranging. This allowed it to include the full context of the operation that led to the shooting and to include considerable focus on supervision. Indeed, the IA investigator was explicitly directed "to investigate/review this incident from the initial stages of the warrant through the shooting incident." The impetus for this broad approach was the early recognition that the GET team sergeant's decision to open the driveway gate at 3:30 was counter to his agreement with the other supervisors. Further, this action was taken without informing the other participants and may have exacerbated the unpredictable elements of the operation. IA's thorough delving into this area also provided the Training Division with the information necessary to provide a full and meaningful analysis of the tactical issues.

Despite the generally thorough work, investigators did not fully address the question of why other officers in a position to shoot at Mr. Coady chose not to fire

their weapons. While every officer's perspective is different and their assessment of the potential threat presented may be different depending on even slight changes in location, the Vancouver detective stood directly behind Officer Corno at the moment he fired at Mr. Coady. During his interview with PPB investigators, the detective discussed the theoretical danger posed by Mr. Coady, but investigators did not directly question him about his actual sense of threat. This information would have been relevant to the question of the reasonableness of Officer Corno's actions.

Training Division Review

Search and arrest warrants, especially multi-target simultaneous warrant operations, are complicated. They involve days of planning, information gathering, a formal operations plan and much more teamwork than more typical patrol operations. The inclusion of additional agency participants adds more layers of complexity.

The analysis performed by Training Division of this incident is incisive and very frank. On many tactical issues it provides great illumination to the Bureau and the recommendations concerning officer safety, better preparation for serving search warrants, and communications training are concrete and far reaching. At least one of these has been implemented – the recommendation that ballistic shields, a portable partial defense against firearms, be placed in every supervisor's car in the field. This suggestion emanated from Training's observation that the officers who approached the main shed were not sure if Mr. Coady was armed and had very little hard cover nearby. The Bureau purchased shields for supervisor cars the following year and provided training in their use. This is now standard practice in the Bureau.

The Training Review does not hesitate to level pointed criticism at the team sergeant for opening the driveway gate at the location. It points out that for the sergeant to take independent action and not inform the team at the briefing was a "betrayal of trust" especially important for small specialized teams. The Review also points out that one officer knew that the team sergeant had opened the gate, had misgivings about it, but failed to speak up at the briefing before the execution of the warrant for fear that the sergeant's act might have been illegal or it might disrupt the search warrant service. Training Division Review then attempted to tackle a major issue of police culture:

The Bureau needs to find a way to overcome people's hesitancy to give information that could be embarrassing, especially when something is unsafe, illegal, unethical or immoral. This is a hard balance to achieve but there should be an environment created where officers feel safe to speak up when it is necessary to do so.

This recognition begins an important discussion of an issue that will not be resolved by one case analysis or even by a written order, but Training's link of this organizational problem to significant officer safety issues is indicative of an organization willing to take a wide angle on problems and not simply attribute them to the shortcomings of individual officers.

The Training Review briefly touched upon the issue of officer fatigue. Ample evidence in the Detectives and IA investigation showed the team sergeant had had no rest for 24 hours and several of the involved officers, including Officer Corno, had been borrowed for this assignment from their normal duties over the previous 48 hours and had very little sleep. Fatigue was widely recognized as a possible factor in the decision making in this operation. Training Division, however, did not address the issue in their recommendations.

Recommendation 7: The Bureau should consider whether some work place limits should be placed on specialized units' engaging in high risk operations so that fatigue will not impact decision making and potentially compromise officer safety.

Accountability for the Supervisor

The Use of Force Review Board recommended that a performance review be conducted on the actions of the team sergeant and the one officer he informed of his opening of the compound gate. Both had helped conduct the briefing just before service of the warrant; neither had mentioned that the sergeant had opened the gate. The performance review resulted in formal discipline being imposed on the sergeant. This was appropriate corrective action against this supervisor for his serious lapses in judgment. The officer was not disciplined. Even if the officer who knew about the sergeant opening the gate was not formally disciplined, there should have at least been some form or remedial action taken against the officer consistent with the concerns raised in the Training Analysis. There is no documented evidence that any remedial action was taken against the officer.

Subsequent Shooting by the Same Officer

Officer Corno was involved in another shooting a little more than a year after this incident. While acting in their capacity as SERT officers, he and another officer were posted behind the cover of a large tree on the periphery of an active scene with an armed individual. The person, Osmar Lovaina-Bermudez, had unexpectedly broken out of the back of a metal shed carrying a revolver and ran through backyards. He grasped the top of a wooden fence with both hands and began to pull himself up. Officer Corno perceived that the hand holding the revolver was aiming it at him and his partner behind the nearby tree and fired three rounds, wounding Mr. Bermudez twice in the chest. His partner officer stated that he perceived the same threat but held his fire. We provided a full description of this shooting incident in our Second Report.

Every incident is different in its details and in the precise decisions that an officer makes based on those details. Nevertheless, officer-involved shootings are revealing events that show how the Bureau as a whole and its individual officers operate under high-risk conditions in the field. In this regard, it is appropriate and necessary to consider whether two shootings involving the same shooter officer reveal any patterns or parallels that could help inform corrective action or other reforms or remediation. The internal investigations and analyses performed by the Bureau on the Bermudez case in 2009 and 2010 did not acknowledge or delve into the possible overlap issues from the Coady and Bermudez shootings. The fact that, in both incidents, Officer Corno saw a firearm, inferred an aggressive threat, and fired almost immediately, whereas nearby partner officers did not fire, should have caused the Bureau to consider whether this raised any issues of training or interpretation of policy specific to the shooter officer. There is no documentation that it did so.

The Use of Force Review Board concluded their proceedings in Coady about two months before the Bermudez shooting. This chronology of critical incidents and Bureau review suggests a missed opportunity. As soon as possible following a critical incident in which the Bureau identifies issues about the use of deadly force or tactical decision making, it should communicate those concerns to the involved officer so that this information might inform his choices should he face similar tactical challenges.

Recommendation 8: The Training Analysis should be privy to and reference any prior deadly force incidents by officers when analyzing the incident at issue. The analysis should look for commonalities of officer performance between the incidents.

Recommendation 9: When an officer is involved in a subsequent shooting, the Review Board should consider whether there are significant parallels between the officer's tactical decision making in the two incidents and, if so, whether they suggest additional remedial action.

November 23, 2010 ◦ Craig Boehler

At about 12:40 a.m., a group of six officers and an acting sergeant responded to a radio call of a disturbance at a two-story, single family house. The caller said that a male was attacking a female and the caller had accidentally shot the male. While the officers were in transit, this was updated to say that the male was still walking around. A further update said the male was continuing to attack the female.

The call had originally come into the Bureau of Emergency Communications (BOEC) from the stepfather of Craig Boehler. He said that when Boehler, his adult son, began to attack his adult daughter, he had armed himself with a handgun and tried to intervene. Boehler tried to throw the stepfather down the stairs when the stepfather said his gun went off and a bullet struck Boehler in the side. After the shooting, Boehler had remained conscious and walking around and had said, "Shoot me. Shoot me."

Within a few seconds of receiving the call, BOEC dispatched a fire unit and ambulance to the scene. Because the scene is six blocks away from East Precinct, many officers responded to the BOEC dispatch quickly. The first officers began arriving at the scene a minute and a half later. Two sergeants, an acting sergeant and seven PPB Officers including a K-9 handler who was also a SERT officer arrived at the scene. One of the sergeants established herself as the incident commander and distributed tasks to the responding officers, including containment of the location.

BOEC continued to provide details of the preceding events, including that the gun used by the step-father was a 9mm handgun and was still in his possession but was unloaded. Also, there were two more guns in the house, a rifle and a shotgun, but that they had been "put away and hidden" from Mr. Boehler.

The incident commander sergeant assembled a team of officers and approached the house from the front. It was a two-story house with an exterior stairway in the middle leading to the front door on the second floor. The front door was open as was the garage door. A door inside the garage was also open. Some officers covered the front door while others approached the garage door. An elderly woman came out of the inner door in the garage and told officers that her son had been shot and that he was attacking her daughter. The officers moved the woman to safety. A few minutes later, a man slammed the front door. An officer observed the man through a window to the side of the front door moving large

objects behind the door, apparently to barricade it. A younger woman, the adult daughter, came out of the inside garage door and fell to the ground. Officers picked her up and carried her to safety. As they did this, an elderly man, the step-father, came out of a door under the front exterior stairs. He too was evacuated from the scene.

The incident commander sergeant determined that, with the three family members safely evacuated, Mr. Boehler was the only one remaining in the house. She ordered officers to retreat and to seek hard cover.

Minutes earlier, as officers had begun to approach the house from the front, a second sergeant, organizing the containment at the back of the house, reported that the individual was trying to flee from a rear second story window, but that he had retreated back into the house before climbing out of the window. The incident commander decided to pull the officers back and ordered all officers on scene to back up and get to "hard cover" to set up a containment. As this was occurring, officers heard a single shot from inside the house. The incident commander activated SERT. She coordinated the evacuation of neighboring residents who might be in the line of fire. She and the second sergeant, who was responsible for coordinating the perimeter, arranged for additional AR-15 officers.

More shots from inside the house followed. Officers who had taken cover at the rear of the house heard bullets go by and felt debris. An officer reported that they were being shot at. The incident commander ordered them to retreat further and leave the back yard in order to maintain a safe containment of the scene. They moved inside a neighbor's house to the rear and the side of the house. Officers heard more shots but could not tell where they were aimed or exactly where the shooter was. BOEC broadcast that officers at the scene reported shots fired inside the house and then toward officers outside the house. Some officers observed Boehler through windows continuing to barricade areas of the house.

A captain assumed command of the scene. SERT officers began to arrive and to relieve other officers in containment positions and to try to find positions that afforded hard cover and adequate containment in the rear of the residence. SERT officer Peter McConnell and another SERT officer sought positions of cover in the backyard of the house adjacent to the Boehler residence. They positioned themselves behind a tree from which they could see into the backyard and the back windows of the Boehler house.

An officer saw Mr. Boehler briefly in the garage at the front of the house and reported that he was carrying a handgun and a rifle. SERT officers began to move armored vehicles toward the front of the house. Officers heard shots and reported that the armored vehicles were being fired upon from the house. When this occurred, a SERT sergeant ordered SERT officers to launch gas into the residence to discourage gunfire from Mr. Boehler. Several SERT officers fired "cold" tear gas canisters into windows of the house. A few minutes later, "warm" gas canisters (thermal canisters that proliferate the gas faster) were launched into the house as well. The use of the gas began approximately an hour and 20 minutes after officers first arrived at the scene.

A member of the SERT Hostage Negotiation Team (HNT) placed several calls to the house but Mr. Boehler ignored them and did not pick up the phone. An HNT negotiator in one of the armored vehicles addressed Boehler by loudspeaker stating that the police were outside the house and ordering Mr. Boehler by name to exit the house with his hands in the air. Boehler fired more shots and otherwise did not reply.

As gas dispersed in the house, officers observed Boehler moving around inside. While his partner donned his gas mask, Officer McConnell watched Boehler through a back window holding a cloth in one hand and trying to light it with a cigarette lighter in the other hand, and then walking out of view. The officer again saw Boehler through the window walking with a pistol in his hand toward the front of the house. At that time, other SERT officers broadcast that they heard shots coming out of the front of the house. Boehler again came into Officer McConnell's view. Boehler turned back toward the front of the house, holding his arm straight down as if he still had a pistol in his hand, although Officer McConnell could no longer see a pistol from his angle. The officer concluded that the gas was not causing Boehler to give up and leave the house and decided to fire his rifle at Boehler, fired three shots and watched Boehler drop immediately to the floor out of sight. He broadcast this to the officers at the scene.

SERT officers launched more gas canisters into the house, then saw flames and smoke in the house. SERT communicated with the Portland Fire Bureau personnel staged nearby and arranged to protect them while they put out the fire. Firefighters extinguished the fire in the house, which was described as "almost completely gutted" by the fire.

Mr. Boehler was found inside the house, deceased. He appeared to have barricaded himself with a .22 caliber Ruger pistol, a bandolier of shotgun shells, a kitchen knife, a cleaver and a hunting knife, and an inert hand grenade in a waist pouch. There was a butane cigarette lighter under his body. Elsewhere in the house were a rifle (not loaded), a semi-automatic Beretta pistol, and parts of a double barrel shotgun. His body showed four bullet entry wounds. The medical examiner determined that one of those was a "contact shot" made by a firearm held very close to Mr. Boehler's abdomen. That bullet was probably the one fired by his stepfather and did not damage any organs or vital tissues. The other three wounds, in the chest, arm and buttocks, appear to correspond to the SERT officer's three shots and caused damage to the bones and intestines. The medical examiner determined that despite these damaging wounds, the cause of death was smoke and carbon monoxide asphyxia from the fire.

In total, an estimated 30 rounds were fired at the scene, all of them except Officer McConnell's three rounds, were fired by Mr. Boehler. Bullet strikes on nearby houses after the incident supported the officers' descriptions of rounds coming in their direction.

Timeline of Investigation and Review

11/23/2010	Date of Incident
12/7-8/2010	Grand Jury proceedings
4/15/2011	IA Investigation completed
12/27/2011	Training Division Review completed
5/1/2012	Commander's Findings completed
6/20/2012	Police Review Board

Analysis/Issues Presented

Initial Command of the Scene

An active shooter and the arrival of a large number of officers over a short time present special challenges to the incident commander to deploy personnel quickly and effectively but to keep them safe and updated with information, to anticipate escape routes, to evaluate the danger to the immediate neighbors and commence evacuations if necessary, to anticipate SERT's needs and to avoid foreclosing HNT's opportunities to negotiate. These multilayered tasks appear to have been handled in a timely and methodical way in contrast to some of the equally complicated barricade situations that we have discussed in our previous reports. Most striking of all, in relation to some of those other incidents is the frequent and effective communication of updated information to all Bureau participants at the scene by the original incident commander and her replacement. The first incident commander sergeant appears to have been particularly focused on avoiding confusion among the dozens of officers deployed at the scene, conducting a roll call periodically to insure that all officers present around the house were in position and accounted for and able to hear information and orders that were broadcast.

Communication

Officer witnesses described Mr. Boehler's shots out the front of the house as "at the armored vehicles." Neither the detective nor IA investigations established whether all personnel in the front of the house were in these vehicles or whether there were additional officers behind potentially more vulnerable cover. In any case, Officer McConnell was not asked if he believed there were officers in front of the house outside the armored vehicles. More importantly, it is not clear whether either circumstance would have affected Officer McConnell's decision to use deadly force when he did. He stated at one point in the investigation that he was also concerned about the safety of neighbors. (*See also* comments below regarding IA investigation report.)

SERT Tactics

Despite the assurances of family members that the firearms in the house had been hidden away, Mr. Boehler was later observed by officers to be moving around inside the house carrying a rifle or a pistol. SERT officer McConnell misunderstood this broadcast to state a rifle *and* a pistol and was aware that this

rifle was probably a high-powered hunting rifle, and according to his statements, was especially cautious because of that. He opined that very few barriers provided safety against such a weapon, but that the Bear Cat armored vehicle and the Bear Truck armored vehicle, both of which had been driven to the scene by Officer McConnell and one of his partners could "combat that type of weapon." He knew that the two armored vehicles were in front of the house where some of his fellow officers were located.

Officer McConnell's statements regarding his decision to fire his rifle at Boehler make it clear that he feared that Mr. Boehler would continue to fire out of the front of the house posing a great danger to the officers stationed there. He also stated that while selecting and taking his containment position in the back of the house, he was worried that the noise he and his partner made crossing the frozen ground and the sparse cover put them at risk before they found cover. However, he did not indicate whether the danger to himself or his colleagues in the back of the house was a present concern at the time he pulled the trigger. He also did not indicate whether he believed the officers in the front of the house all had sufficient cover inside the armored vehicles. This is not to suggest that Mr. Boehler did not pose a significant threat to the officers surrounding the house who were not in armored vehicles. But had Officer McConnell been questioned about these specific points, it would have clarified his knowledge and state of mind regarding this crucial tactical decision and whether any other tactical options presented themselves.

The officer who shot Mr. Boehler was part of a complex and generally well-organized tactical operation that exhibited patience on all fronts despite Boehler's actions to barricade himself, fire his gun toward officers outside the house and finally set the house on fire. Officer McConnell's independent decision to shoot in order to stop Mr. Boehler was in contrast to the discipline exercised by the rest of the team. For that reason, it falls to the Bureau to ask if there was an actual exigency that made the use of deadly force necessary at that moment. Should the officer have notified the incident commander of his intent or radioed to communicate his concern to colleagues before using deadly force? How did the observation that Boehler appeared to be trying to start a fire contribute to the need to use deadly force? The investigation and review did not explore these questions.

"Completing" the Delivery of Gas Canisters

Shortly after 2:00 a.m., Officer McConnell broadcast that he saw Mr. Boehler on the top floor of the house lighting something on fire. One minute later, Officer McConnell broadcast that he had shot at Boehler who then fell to the floor in the southwest corner of the top floor of the house. SERT officers, on supervisor's instructions, then launched a final volley of "warm" CS gas (similar to tear gas) into the house. Twenty-five minutes later SERT officers observed a fire in the lower level of the house. The tactical motivation for "completing" the CS gas delivery after the sniper shots were reported is not clear and was not explored by IA or Training. While the Commander's Finding stated that the purpose was to "further hamper Boehler and force him out of the house if he was able to move," it is not clear whether this is a statement of doctrine or an actual reflection of the SERT mindset at the time. The Portland Fire Bureau Arson Investigator in this case determined that, based on forensic evidence at the scene and interviews of the family and participants and the origin locations of the fire, "all warm gas canisters were ruled out as being in an area of origin and causation of any fires."

Medical Attention to the Downed Individual

The incident commander directed emergency medical services to stage near the scene at the earliest opportunity, while the standoff with Mr. Boehler was ongoing. Paramedics could not enter the house immediately after Boehler was shot by a SERT officer because it was not known if he was still armed and conscious, and there was a growing fire in the residence. Medical staff could not enter the house until the fire was extinguished and SERT officers had cleared the house to ensure that Mr. Boehler no longer posed a threat, two hours after shots had been fired by Officer McConnell. While we have been critical in prior reports and elsewhere in this report of PPB's delay in rendering medical assistance to persons injured as a result of police actions, the fire here presented a unique circumstance that justified this lengthy delay.

Quality of Investigation and Review

Cause of Death

The medical examiner explicitly named two causes of death in her report of the autopsy she performed on the same day as the incident: "I. Asphyxiation by

inhalation of smoke and carbon monoxide; II. Gunshot wounds of abdomen and arm." Two weeks later she stated to the Grand Jury that, "So now we have got all these gunshot wounds…. They are there, certainly would have caused pain, but they don't cause his death…. So what we did was a special test for carbon monoxide of the blood…. And he has 49% and 49% is a lethal level of carbon monoxide. So he died of carbon monoxide poisoning. He did not die from his gunshot wounds." The medical examiner was not asked by Bureau investigators about an apparent evolution of her conclusion regarding cause of death. IA should have interviewed the medical examiner about this issue.

Internal Affairs Division Investigation

The IA report confines itself almost exclusively to the tactical and policy issues concerning the SERT officer's shooting of Mr. Boehler. IA thoroughly explored those issues, setting out each important aspect of Officer McConnell's observations, tactics and decisions, with one crucial exception. Officer McConnell stated that he decided to fire his rifle at Boehler because he believed, if Boehler moved again toward the front of the house, he posed an immediate threat to the officers out front. The critical incident commanding captain as well as Officer McConnell, who had driven one of the armored vehicles to the scene, both believed that the armored vehicles themselves offered good protection against Boehler's firearms. They believed this was the case even if Mr. Boehler had used the scoped hunting rifle his relatives had said was in the house. IA should have attempted to resolve the apparent contradiction between Officer McConnell's belief that the officers in the front of the house were vulnerable and his view that the armored vehicles were good cover. Unfortunately, their questions did not focus on his concrete concerns, despite that they were the basis for his decision to use deadly force. Moreover, it would have been helpful to have interviewed someone with expertise in the penetrating ability of the firearm in question, vis a vis the armored vehicles deployed, so that the Bureau could learn and then inform its officers about whether Officer McConnell's concerns were real or illusory.

The Training Division Review

The Training analysis exhibits a highly structured format that examines each phase of the operation in a methodical manner. Its recreation of the command and tactical decisions made at the scene is detailed and illuminating. It delves into areas of potential importance that do not turn out to be significant due to the turn of events. For example, Training examined the difficulty of establishing safe

perimeter positions at the back of the residence, the unnoticed vulnerable location of the command post, and the challenges presented by the unavoidable piecemeal arrival of SERT officers. Training's analysis further paid attention to the need for discipline in radio communications and BOEC's role in keeping officers focused on only essential communications during a critical incident. Training recommended that BOEC dispatchers receive a new kind of training parallel to the critical incident management class that the Bureau provides to supervisors. Internal Affairs has found no documentation that such training was ever offered or accepted by BOEC. Since BOEC is a separate City bureau, PPB does not have authority to require such training but it should consider engaging BOEC with the offer of this mutually beneficial training. The City should require BOEC operators to take part in this training.

Recommendation 10: The City should consider requiring BOEC dispatchers to attend Critical Incident Management Training.

The Training Review does tread lightly in some important areas however, such as the possible inconsistency between Officer McConnell's belief that the armored vehicles provided effective cover against even a scoped rifle and the fact that the threat to the officers in the armored vehicle was his expressed reason for firing on Boehler. It also defends the use of gas as appropriate and well organized but fails to address the continued use of gas following Officer McConnell's apparently effective use of deadly force because, among other reasons, he perceived that the gas was not going to work on this individual.

The Training analysis was not completed until more than eight months after the Internal Affairs investigation and report. While this was not the only source of unusual delay in this case – the Commander's finding took an additional four months to complete – the Training review delay was a major contributor to a timeline that brought this incident before the Police Review Board a full nineteen months after the original event.

December 17, 2010 ◦ Darryll Ferguson

On December 17, 2010, Portland Police Officers Jonathan Kizzar and Kelly Jenson responded to an apartment building after Darryll Ferguson called the police alleging that his neighbor was making threats to him over the telephone. On the way to the call, the officers were able to retrieve a photograph of Mr. Ferguson on their radio car computer. As the officers approached the apartment, they observed a man they recognized as Mr. Ferguson flagging them down outside a mini-mart store. The officers proceeded to ask him about the nature of his complaint. According to the officers, Mr. Ferguson was not particularly forthcoming about his complaint and became defensive when the officers asked why the neighbor may have become agitated. Mr. Ferguson then advised the officers that he would handle the matter himself and walked into the apartment building. The officers received another unrelated call for assistance and decided to respond to that call rather than continue to attempt to follow up on Mr. Ferguson's complaint.

While assisting with the unrelated call, the officers heard over the radio that another officer had been dispatched to the apartment as a result of the neighbor now complaining that Mr. Ferguson had threatened him. Because the officers had responded to the first call, they instructed dispatch to reassign the call to them and returned to the apartment building. On their way to the call, they made telephone contact with the neighbor. The officers also received information via their in-car computer that Mr. Ferguson may have been observed with a firearm several days earlier. The officers knocked on Mr. Ferguson's door without identifying themselves as police officers. When the door opened, the officers saw what they believed to be a firearm pointed at Officer Jenson. Officer Jenson turned and moved away, Officer Kizzar backed up and fired 15 rounds through the apartment wall, and when Officer Jenson completed his turn, he fired five rounds at Mr. Ferguson. The officers moved for cover on both sides of the apartment hallway and the apartment door closed.

According to Mr. Ferguson's girlfriend who was in the apartment with him at the time of the shooting, she heard knocks on the apartment door and looked through the peephole but did not see anyone. She said that Mr. Ferguson then told her that he would answer the door and when the door opened she heard multiple gunshots. When the shooting stopped, she saw Mr. Ferguson lying near the door with a gun nearby. She picked up the replica nine millimeter BB gun and placed it on the kitchen counter. She cried out that Mr. Ferguson was bleeding and needed

paramedics. Officers then ordered her out of the apartment at gunpoint. The girlfriend also reported that several minutes later, her daughter, daughter's boyfriend, and child, who were all inside the apartment at the time of the shooting, were also ordered out of the apartment.

According to Bureau records, seven minutes after Officer Kizzar broadcast over the radio that shots had been fired, he further radioed that it sounded like there was a female inside the apartment. Two minutes later, one of the responding sergeants directed that some ballistic shields be brought to the apartment. At around this time, the girlfriend came out of the apartment. Approximately 10 minutes later, information was broadcast that a sergeant was on the phone with the people remaining in the apartment followed by a broadcast that two adults and a child were coming out of the apartment. As they left, the apartment door closed behind them. Six minutes later, a sergeant requested SERT. Officers later learned that Washington County's SERT was standing in for Portland's SERT team. During this time, officers evacuated the floor of the building where the shooting occurred. When this was completed, the decision was made by the on-scene incident commander to designate PPB officers to enter the apartment rather than wait further for Washington County SERT to respond. Portland officers then entered the apartment and noted that Mr. Ferguson was lying near the door apparently deceased. Immediately after the officers entered – 84 minutes after Officer Kizzar radioed that shots had been fired – a medic entered the apartment and determined that Mr. Ferguson was, in fact, deceased. A replica nine millimeter BB gun was found on a counter inside the apartment.

Timeline of Investigation and Review

12/17/2010	Date of Incident
3/15/2011	IA Investigation began
6/30/2011	IA Investigation completed
11/7/2011	Commander's Findings completed
4/20/10	Training Division Review completed
1/18/2012	Police Review Board

Analysis/Issues Presented

Performance of Portland's Bureau of Emergency Communications

The investigation captured two conversations between Mr. Ferguson and dispatch personnel from BOEC. In both conversations, when Mr. Ferguson explained the nature of the call, the personnel informed him that the call did not qualify as an emergency and that he should call the non-emergency telephone number. Mr. Ferguson can be heard to express exasperation and frustration at those instructions and claimed that his phone was not able to reach that number. He asked dispatchers to transfer him to the non-emergency line, but they indicated that they were not able to do so. A review of the conversations between Mr. Ferguson and the dispatchers indicated that they eventually grew impatient with Mr. Ferguson tying up the emergency line, while Mr. Ferguson was clearly dissatisfied with the way his complaint was being handled.

The performance of the dispatchers apparently was not examined during any part of the review process. The impatience they expressed toward Mr. Ferguson was somewhat understandable, given their need to keep the emergency line clear. However, by failing to have those conversations assessed by supervisory communications staff, the City gave up the opportunity to use the incident as a potential learning experience and teaching tool. Moreover, if in fact BOEC staff is unable to transfer a call to a non-emergency line, this incident could have been used as an opportunity for discussion as to whether such a capability should be explored. Review of critical incidents should endeavor to identify collateral issues that can be used to improve individual performance and systems and practices. We remind the Bureau of our prior recommendation and its acceptance of the recommendation that, on a forward going basis, supervisors from the City's emergency communications center participate in the Bureau's review process when there is an emergency call component to the incident.

Initial Handling of Call

When Officers Kizzar and Jenson first responded to the apartment building, Mr. Ferguson flagged them down outside a nearby convenience store. Mr. Ferguson refused to provide details about the nature of the threats from his neighbor and grew defensive when the officers asked him about whether his actions may have contributed to the discord. The officers then ended their engagement with Mr.

Ferguson when he said he would take care of the "problem" himself and walked toward the apartment building "ranting and raving the whole way back" in the words of Officer Jenson's grand jury testimony.

There is scant analysis during the Bureau's review process about whether the way in which the responding officers "cleared" the first call was consistent with Bureau expectations. Mr. Ferguson's "ranting and raving" display and remark that he would resort to self-help suggests that it may not have been advisable for the officers to have summarily ended their response at that juncture. As the scenario eventually played out, the conflict between Mr. Ferguson and his neighbor escalated and worsened, requiring a return visit by the officers. While the officers explained that their decision to end their first visit was impacted in part by receiving an assistance call from a fellow officer, there was no significant assessment during the Bureau's review process of how the officers handled the first visit, the degree of exigency of the unrelated call, whether ending their contact with Mr. Ferguson to assist on the related call was appropriate, and whether a more sustained response during the first visit would have been advisable.

Failure to Notify Dispatch of Arrival on Scene

When Officers Kizzar and Jenson returned to the apartment building, they failed to formally notify the dispatch center of their arrival time. As a result, the first radio communication heard from the officers is when they announce that shots had been fired. The failure of the officers to formally announce their arrival made it impossible to precisely pinpoint a chronology of events with regard to when they arrived at the location and when shots were fired. The Training analysis noted that the officers' failure to notify dispatch was not consistent with training. This failure to notify dispatch was also noted in the Commander's Memorandum in which the Commander recommended that supervisors continue to emphasize the importance of officers updating dispatch with their location and arrival on scene. There was no documentation indicating that this performance issue was ever personally briefed with the involved officers or formally exported to the Bureau through a training bulletin.

Tactical Planning

Officer Jenson indicated that while they were in the car, he and Officer Kizzar formulated a plan to knock on Mr. Ferguson's door and ask him to leave his neighbor alone. Officer Kizzar said that he did not remember talking to his

partner beforehand regarding any plan on how to deal with Mr. Ferguson and relied on their past work experience on how they would deal with him. Even though they had information that Mr. Ferguson had been observed with a firearm several days prior, this fact did not enter into their discussion on how they would approach Mr. Ferguson's apartment. The Training Division Review noted that, as a result, no plan was in place to address the possibility that Mr. Ferguson might be presently armed and that the lack of a plan was not consistent with the Bureau's training regimen. In the Commander's Memorandum, there is a recommendation that supervisors continue to emphasize operational planning at every level. However, there is no documented evidence that the involved officers in this case were ever briefed about whether there could have been improved planning and discussion between them prior to entering the apartment building, particularly with regard to the possibility that Mr. Ferguson might be armed nor is there evidence that this concept was ever formally reinforced Bureau-wide.

Decision to Shoot Through the Apartment Wall

When Officer Kizzar observed Mr. Ferguson point a firearm at his partner, he shot fifteen rounds through the wall because he was not in a position to acquire a sight target on Mr. Ferguson himself. The Bureau's reviewers concluded such use of deadly force was reasonable in order to protect the life of his partner. What the review process did not clearly articulate were the disadvantages of such actions – how bullet trajectories are impacted when going through solid substances, the reduced likelihood of the bullets striking the intended target, and the increased likelihood that the rounds would strike unintended targets such as other apartment residents or that they would ricochet in the direction of the officer's partner. In this case, the rounds fired by Officer Kizzar had no effect on the subject or anyone else. However, any full analysis should articulate the potential outcomes (both desirable and not) in shooting through walls, even if the eventual calculus is that the deadly force was appropriate despite the potentially undesirable outcomes.

Failure to Consider Plausible Alternative Scenario

The investigation revealed numerous telephone conversations going back and forth between Mr. Ferguson and his neighbor. Both Mr. Ferguson and the neighbor called police to report that each had threatened the other. When Officers Jenson and Kizzar arrived at Mr. Ferguson's apartment and knocked on the door, they indicated that they positioned themselves to the side of the door and did not announce themselves as police officers. The officers' positioning may explain

why Mr. Ferguson's girlfriend reported that when she responded to the knocks and looked through the peephole on the door, she did not see anyone in the hallway.

Accordingly, one alternative plausible scenario is that when Mr. Ferguson instructed his girlfriend to move away and that he would answer the door, he likely expected that the 4:00 am visitor who was knocking on his door was the neighbor with whom he had been having repeated confrontations during the night. Infused with that belief and potentially impacted by his intoxicated state, Mr. Ferguson may have decided that he would surprise and frighten his neighbor by answering the door with a replica firearm pointed directly at him, much the same way he had been acting with his other neighbors in recent prior occasions, only to encounter two police officers instead. Mr. Ferguson's intoxicated state may have prevented him from being able to change his course of action before the officers used deadly force on him.

It is important that any critical incident review consider alternative plausible scenarios, particularly when the review is attempting to understand the actions of an individual who points a replica firearm at two armed officers. Moreover, while recognizing alternative plausible scenarios will not necessarily result in a different view of the officers' ultimate decision to use deadly force, it might illustrate the need to promote tactical decision making such as ensuring that officers announce themselves as police officers in similar future scenarios. Reviewers should push to try to understand actions of those they encounter and whether any other reasonable tactic could have achieved a different result. Weighing the possibility of alternative scenarios is an efficacious way to develop such strategies.[11]

[11] The Bureau points out that the above statement is "speculative" and does not acknowledge that Ferguson is still responsible for his decision to open the door and point a replica gun at anyone who was at the door. The Bureau also notes that it leaves to officers' discretion whether to announce presence (or not), leaves to the officers which tactics to deploy, and trains officers to avoid standing in front of doors. Finally, the Bureau notes that the Review Board discussed the decision not to announce after this incident at great length and determined that the officers acted appropriately. We acknowledge that because Mr. Ferguson is no longer alive, his motivation and intent at pointing the replica firearm will never be known, that his decision to do so at anyone was not appropriate, and that the Bureau has no policy dictating whether its officers should announce their presence. Our point is that unless a reviewing organization is willing to consider "speculative" alternative plausible scenarios, it loses the potential that such a mental exercise could be used to improve the police agency as it faces future tactical challenges.

Delay in Providing Medical Attention to Subject

As noted above, after the shooting by Officers Kizzar and Jenson, the apartment door swung closed as the officers moved to the ends of the apartment hallway. The involved officers were soon replaced by non-involved responding officers and escorted outside the building. According to Mr. Ferguson's girlfriend, after the shooting ended, she observed Mr. Ferguson down near the doorway and bleeding. According to her account, she shouted that Mr. Ferguson was bleeding and in need of paramedics. When her entreaty received no apparent response, she opened the apartment door and repeated her request. She indicated that she was first instructed by officers to go back inside the apartment and then shortly after that was ordered to come out of the apartment with her hands up, which she did, and was escorted downstairs by officers. The girlfriend said that she continued to assert that Mr. Ferguson was bleeding and in need of medical attention, but the officers indicated that they needed to call a special entry team before they could go inside the apartment.

The other three residents of the apartment, the girlfriend's daughter, her boyfriend, and their three-year-old son were also inside the apartment at the time of the shooting. The boyfriend said he observed Mr. Ferguson lying near the apartment front door in a pool of blood. The boyfriend reported that his girlfriend eventually received a call from police on her cell phone and was instructed to vacate the apartment. He said that they complied with the officers' request and as they walked by Mr. Ferguson lying near the door he tried to shield his son's eyes from that sight.

Officers did not clear the apartment to allow paramedics to attend to Mr. Ferguson for 84 minutes after shots were fired. Neither the criminal nor the administrative investigation of the incident focused significantly on this delay. The Commander's Memorandum noted that after the occupants of the apartment were debriefed, the incident commander eventually decided to make entry prior to Washington County's arrival to render aid to Mr. Ferguson more quickly. The Bureau found that the responding officers' and supervisor's post incident actions in providing emergency medical aid was within policy.

There was no documentation of any discussion during the investigation or review process about whether officers Mr. Ferguson could have safely provided medical attention more quickly. As noted above, the Mr. Ferguson's girlfriend indicated

that she told officers that Mr. Ferguson needed medical attention shortly after the shooting. Neither Detectives nor IA investigators asked responding officers about these representations nor were they questioned about whether they considered making entry into the apartment as they were instructing the girlfriend and other occupants to leave. Nor was there any questioning or assessment into Bureau supervisors' decision to evacuate an entire floor of apartment residents before attempting to make entry to check on Mr. Ferguson. It is also not evident from the investigative file why Portland's SERT was unavailable to respond to this incident. Finally, it is not clear what circumstances changed to cause the Bureau to finally enter the apartment before Washington County SERT arrived. While the Commander's Memorandum suggested that it was after the occupants of the apartment had been debriefed that the decision was made to go in with uniformed personnel, the occupants indicated that they provided information about Mr. Ferguson's condition within minutes of the shooting.

A related area of inquiry that was not explored was the method through which the occupants of the apartment were escorted away. For example, investigators asked no questions about when telephone contact was made with the couple, or whether it could have been possible to have them describe Mr. Ferguson's condition more precisely.

We believe it is incumbent upon the Bureau to engage in a more exacting review of actions by its members in providing timely medical aid and to consider alternative scenarios that might improve such a response, particularly in light of our observations in prior reports about delay in rendering aid as well as similar concerns having been lodged by members of the Portland community.

A related area of inquiry in which there is a factual deficit is information about the decedent's injuries. The medical examiner's report does not opine about the lethality of the gunshot wounds sustained by Mr. Ferguson and whether the wounds would have been survivable if immediate medical attention had been provided. The significance of this information is obvious, and it would be helpful for the Bureau to solicit the medical examiner's opinion on this issue in future cases.

While in some instances it may be difficult for the medical examiner to conclusively opine about the lethality and survivability of the gunshot wounds, there is no harm in asking the question and documenting the response.

Recommendation 11: As part of its investigative protocols, the Bureau should inquire of the medical examiner about the survivability potential of any downed subject who is not provided immediate medical attention.

Quality of Investigation and Review

Officers' Refusal to Provide Voluntary Statements to Detectives

As the criminal investigation of the incident began, Officers Kizzar and Jenson declined to provide voluntary statements to investigators. The officers were eventually required to provide compelled statements but not until almost a week after the incident. Approximately two weeks after the incident the officers finally provided voluntary testimony to the grand jury. As a result, PPB did not have a full account of the involved officers' version of events until nearly a week after the incident. And because those accounts were compelled statements that could not be used in the criminal investigation, it was not until the criminal investigation had been packaged and completed and the officers appeared before the grand jury that the criminal review obtained the officers' version of what transpired.

It is less than ideal that the criminal investigation and review does not obtain voluntary testimony from the officers until the grand jury proceedings. First, because the detectives cannot question the officers about their observations and actions, they cannot follow any leads based on those observations. In the past, the criminal officer-involved shooting investigation was built around the voluntary interviews conducted of the officers who possess the most information about the incident and why deadly force was used. Now, the investigation submitted by the detectives to the District Attorney has a huge investigative hole, namely, the observations, thought processes, and actions of those central to the incident. And while eventually the District Attorney does obtain the officers' voluntary testimony at the Grand Jury, that testimony does not have the wide-ranging depth of an investigative interview that we have seen conducted by Police Bureau detectives but is more limited to the mind set and actions of the officers immediately prior to the shooting and, practically speaking, precludes its use for follow up investigation.

The reason most frequently articulated for this relatively recent phenomenon of Bureau officers not providing voluntary statements to detectives is that the routine production and release of grand jury transcripts in addition to a recorded interview with detectives creates the potential for arguably conflicting statements that could redound to the detriment of the officer. However, the creation of multiple

statements from officers is routine in other jurisdictions, and even if there is an arguable conflict with an earlier statement, reasonable arbiters understand and recognize that no two statements will ever be precisely the same. Moreover, there has been no demonstrable evidence that voluntary statements given by Bureau officers to detectives investigating an officer-involved shooting have ever resulted in any real detriment to those officers. It is unfortunate that this speculative concern has influenced officers to not provide a voluntary account of what occurred to detectives for timely use in the criminal investigation.

That being said, officers are entitled to choose not to cooperate in the criminal investigation, and the Bureau must adjust to this change in stance among its officers. More recently, officers who decline to provide voluntary statements are ordered to provide compelled statements as soon as they refuse. However, as we have indicated in earlier reports, those compelled statements cannot be obtained until at least 48 hours after the order is given as a result of a restriction that exists in the current labor agreement between the police officers' association and the City. As we have advocated in prior reports, it is past time for that restriction to be eliminated so that the Bureau can timely learn what its officers observed and did when they decided to use deadly force.

Failure to Timely Document Interview of Critical Witness

After Mr. Ferguson's girlfriend was ordered out of the apartment, she was interviewed by a Bureau sergeant and a non-sworn member of the Bureau's hostage negotiation team. However, it was over a month later before the sergeant prepared a report of his recollection of the non-recorded interview. Rather than prepare a report, the non-sworn member was interviewed by Internal Affairs about her recollection of the incident. One apparently critical fact that the Bureau detectives noted in the investigative report was the sergeant's recollection that the girlfriend had indicated that she had observed Mr. Ferguson go to answer the door with the nine millimeter replica in his hand. However, when the non-sworn member was interviewed, she could not recall this statement by the witness.

It is imperative that when key witnesses are interviewed, the interviews are either recorded and/or documented with a contemporaneous report. Because neither occurred here, the Bureau is left to resort to month-old recollections. That recollection is further undermined by the co-interviewer's inability to recall whether the witness made a certain observation and leaves a significant hole in the Bureau's fact collection process in this case.

Failure to Fully Explore Existence of Video Evidence of the Incident

Detectives responded to the shooting incident and soon learned that the incident may have been captured on the building's video surveillance system. Detectives then interviewed the apartment building manager who told them that the system was not functioning. Almost five months later, the manger contacted detectives and told them that he had seen the shooting incident on the building's surveillance system. Detectives immediately responded to the building and attempted to recover video of the event. Detectives also interviewed the manager who said that he had seen the shooting incident but did not have sufficient memory of what he had seen to answer questions about what the video depicted. Investigators were able to capture video data on the system but only with regard to events occurring after the shooting incident. Investigators speculated that the surveillance data of the incident may have been overwritten by new surveillance data.

Clearly, if video data existed of the shooting, it would have been important to capture for purposes of the investigation. Unfortunately, in the hours after the event, investigators relied on the statement of the building manager that the video system was not functioning, only to be given another story months later. It was impossible at that point to determine whether there was video of the event that was lost. This unsatisfactory resolution could have been avoided had detectives not taken the manager at his word about the equipment not functioning, but actually asked the manager if they could personally examine the system to either verify or refute the manager's story.

Because the initial investigation was a criminal investigation, if the manager refused to provide access to the system, detectives could have applied for a search warrant in order to examine the surveillance system to see whether there was footage. Even if the examination of the system revealed no video depiction of the event, it would have put to rest claims later made in this case that, in fact, such footage once existed. Thoroughly pursuing investigative leads that result in no evidence is as important as pursuing those that result in actual evidence. This saga should serve as critical lessons learned for Bureau investigators to ensure that if there is potential video evidence of a shooting incident, all reasonable efforts be made to determine whether such evidence in fact exists.

Recommendation 12: The Bureau should ensure that its investigative protocols for investigating critical incidents require personal examination of video surveillance systems as opposed to reliance on non-Bureau

member's statements about whether there was a video capture of the event.

Significant Delay in Investigation and Review Process

As detailed above, it took over a year to complete the investigation and review process in this case. We have repeatedly commented on these delays and simply note it here and again implore the Bureau to figure out a way to compress the investigative and review cycle of shootings to a more reasonable time frame.

Officer Notification of Administrative Disposition

The Bureau and Police Review Board found no violations of policy with regard to the actions of Officers Kizzar and Jenson. Investigative records indicate that the involved officers were notified of the results of the administrative investigation via email. When officers are involved in a shooting, the weight of the internal investigation weighs heavy during the extended investigative and review process. It would seem a better practice for the results of that review to be communicated to involved officers in person rather than through electronic mail. Moreover, a personal communication of the "bottom-line" decision of the Review Board could be used as an opportunity for a more wide-ranging dialogue about performance issues identified during the review process that were either exemplary or could have been better. Were Bureau executives to routinely provide more robust feedback to involved officers it would demonstrate to those officers how painstaking the review actually was and provide a learning opportunity to better prepare those officers should they be faced with similar future challenges. As a result of a relatively new Executive Order, the notification process has changed so that the Captain of the Professional Standards Division personally notifies the involved officer of the Review Board's findings by the end of the day.

Recommendation 13: The Bureau should consider developing and formalizing a more personal and robust way to communicate the results and deliberation of the Police Review Board recommendation and Bureau findings to involved officers.

December 27, 2010 ◦ Marcus Lagozzino

At 5:15 p.m. on December 27, 2010, in heavy rain, Central Precinct officers responded to a 911 call concerning a subject, Marcus Lagozzino, who was reportedly armed with a machete, breaking out windows and throwing things in the house. The complainants were the subject's parents, who reported that their 34-year-old son would be confrontational and had "talked about suicide by cop in the past." This information was passed on to responding officers. Two officers initially were dispatched to the call and four others responded to assist, as well as two sergeants.

The first responding officer established a staging area. As officers gathered at the staging area one of the sergeants began formulating an approach plan, dispatch continued to provide updates, including that Lagozzino shouted into the phone, "better get them to shoot me" and told his parents that they were going to get to watch the police kill him. They also learned that the subject was moving in and out of the house and that his parents were hiding inside the house. Mr. Lagozzino had assaulted both of his parents during the encounter. While the parents told dispatch about the assaults, this information was not passed on to responding officers. The sergeant's plan was to take a position outside the house and try to engage Mr. Lagozzino, but to quickly engage SERT and HNT if Lagozzino did not respond positively.

Based on a review of available maps and information received from Mr. Lagozzino's father, officers planned to take two separate approaches to the house. Two officers were to approach from the north and take a position of cover from where they could shine their patrol car's spotlight on the house to help illuminate the dark, rainy night. One of these two – Officer Scott Foster – was designated to deploy a beanbag shotgun, with the second officer as his lethal cover. The second team was to walk toward the house from the west and engage Mr. Lagozzino. A sergeant was with this team and had assigned Officer Ralph Elwood to deploy a beanbag shotgun, with another officer providing lethal cover. Officer Jamin Becker was deployed with a Taser and Officer Bradley Clark with an AR-15 rifle. As this team got near the house, they saw movement in front of the garage and repositioned themselves to create further distance, approximately 40 feet. The sergeant shined his flashlight on Mr. Lagozzino and directed him to come out and show his hands. Lagozzino then began moving toward the officers.

At that point, the team of two officers approaching from the north arrived at their position and shined their spotlight on Mr. Lagozzino, momentarily stunning him

and causing him to pause. Mr. Lagozzino then began either running or walking fast directly toward the contact group of officers while swinging a machete. Multiple officers gave commands to stop, and Officer Elwood fired the beanbag shotgun, which struck Mr. Lagozzino but did not stop his advance. Officer Becker fired his Taser but did not make effective impact, and Officer Foster also fired one beanbag round. As Mr. Lagozzino got within 15-20 feet of the officers, Officer Clark fired four rounds from his AR-15, striking Mr. Lagozzino three times. To some of those involved, it seemed like everyone fired at once. Others recall hearing a beanbag shotgun fired first, seconds before the AR-15 rounds. Mr. Lagozzino took one or two more steps before falling to the ground. His machete fell a foot or two from his body. Neither of the two officers providing lethal cover fired their weapons. One said that he would have fired, but hesitated slightly out of concern for his backdrop, and in that moment's hesitation, Mr. Lagozzino went down. From the time officers began their approach until they broadcast that shots had been fired, one minute and six seconds elapsed.

The second sergeant followed the contact team in a support role and took charge of the scene after the shooting. While Mr. Lagozzino was still on the ground, Officer Foster fired another two beanbag rounds at Lagozzino's legs in response to the subject's movement. The sergeant directed Officer Foster to hold his fire, and then assembled a custody team that moved in almost immediately. They handcuffed Mr. Lagozzino within two minutes of the shooting, rolled him on his side, and waited for emergency medical response to arrive.

Portland Fire & Rescue arrived within three minutes, and paramedics treated Mr. Lagozzino at the scene before transporting him to the hospital. He survived his injuries, and later admitted to Detectives that he had advanced on the officers holding the machete "combat style" with the intent to "[g]et shot dead. . . . Because I failed the past three suicide attempts." Detectives canvassed the neighborhood for witnesses. They found several residents who heard gunshots, but none who observed the shooting or the events that preceded it. Within two weeks of the incident, the Grand Jury returned a "No True Bill" on any criminal culpability for the involved officers.

Timeline of Investigation and Review

12/27/2010	Date of Incident
12/30/2010	IA interview of shooter officer
1/7/2011	Grand Jury concluded
4/29/2011	IA Investigation completed
10/4/2011	Training Division Review completed
2/22/2012	Commander's Findings completed
4/4/2012	Police Review Board

Analysis/Issues Presented

Tactical Planning

The Bureau's reviewer's all commended the involved officers for their performance in response to a highly stressful situation. In general, we do not disagree with the positive assessment of the officers' performance under difficult circumstances. Mr. Lagozzino appeared intent on confronting officers; weather conditions were poor; and the location of the call was in a residential area with winding roads and dead-end streets. With eight officers on scene, four lethal rounds were fired by only one officer at a person who was advancing on them with a raised machete. That level of controlled gunfire and restraint is not often present in the many similar scenarios we have seen confronted by other law enforcement agencies. The on-scene sergeants assumed control of the situation, developed a plan, assigned officers to various tasks, and quickly got medical aid to the wounded subject.

Nonetheless, some aspects of the tactical planning are worthy of discussion. Neither the Training Division's analysis nor the Commander's review raised these issues.

- *Engaging Additional Resources*

The reviewers accepted as fact the view that the sergeant and his team needed to engage Mr. Lagozzino immediately in order to protect his parents. The sergeant likely had a difficult task in balancing the desire to slow down his response to ensure he had all necessary resources with the sense that Mr. Lagozzino may harm his parents. In their call to 911, the parents reported their son had threatened them. The sergeant intended to move close to the house and establish communications with Mr. Lagozzino before attempting to make physical contact with him. However, the subject advanced on officers almost immediately after the sergeant first announced their presence.

It is impossible to know whether Mr. Lagozzino would have further assaulted his parents had officers not moved in as quickly as they did. It is also impossible to know whether a SERT or HNT consult or call out would have led to a peaceful resolution of this scenario. The officers knew that Mr. Lagozzino had made explicit statements about his plan to be killed by police. Whenever a subject presents such a clear suicide and/or homicide wish, the handling sergeant should consider consulting the Bureau's experts – SERT and HNT – before deciding to move in quickly rather than wait for additional resources.

- *Evacuating the Home*

The officers knew that Mr. Lagozzino's parents were still inside the home at the time they moved in and engaged him. The sergeant described them as "hiding" inside. They apparently did not know that Mr. Lagozzino's physically disabled uncle was in the basement apartment. Perhaps the problematic location of the home or other factors would have made it impossible to attempt to evacuate the home prior to engaging Mr. Lagozzino. The dispatcher remained on the phone with the parents as the incident unfolded, but there was no discussion about the feasibility of having them exit the home. Neither IA nor Detectives asked the sergeants or officers whether they considered removing the occupants from the home to eliminate the possibility that Mr. Lagozzino would retreat into the house and hold hostages. Neither the Training Division nor the Commanders who reviewed the incident commented on this issue.

Quality of Investigation and Review

Internal Affairs Investigation

Because Officer Clark declined to be interviewed by Detectives based on his attorney's advice, on the night of the shooting the IA Captain served him with a notice to be interviewed by IA investigators after 48 hours. Detectives proceeded with their interviews of all the officers who used non-deadly force or were witnesses to the event. IA interviewed Officer Clark on December 30, 2010, but then, per usual practice, waited until Detectives completed its investigation before resuming the administrative case. However, IA conducted no further interviews, and IA's investigation consisted of little more than summaries of Detectives' interviews and a transcript of investigators' interview with Officer Clark. Follow-up interviews could have provided the opportunity to explore the tactical issues discussed above.

Medical Records

For a review of fatal officer-involved shootings, significant evidence is routinely captured in the autopsy report, such as a description of how and where bullets entered the body and what path they took within it. In this case, Mr. Lagozzino was shot three times and survived. There obviously was no autopsy report, and neither Detectives nor IA investigators made any apparent attempt to get copies of Mr. Lagozzino's medical records or to talk to any medical personnel who treated him. Mr. Lagozzino may have refused to waive his privacy interests, but it is not clear that he was even asked whether he would sign a waiver and allow access to his medical chart or providers. In any event, Detectives could have gotten a warrant to obtain the records. Because there is little dispute – even between Mr. Lagozzino and the officers – regarding Mr. Lagozzino's movement or position when he was shot, this may be a minor point in this incident. However, in a non-fatal shooting where the facts may not be as clear, the records of the subject's medical treatment immediately after the shooting are a key piece of evidence. Making all possible efforts to obtain them should be a routine part of any officer-involved shooting investigation.

Recommendation 14: The Bureau should consider revising its investigative protocols to require Detectives and/or IA Investigators to obtain the records regarding the subject's post-incident medical treatment following any non-fatal officer-involved shooting investigation.

Training Division Review

The Training Division Review in this case was not completed until nine months after the Grand Jury concluded and five months after IA completed its case. The analysis is largely laudatory and concludes that the involved officers and sergeants acted consistently with their training during all aspects of this incident. It makes just one recommendation: that directives be changed to reinforce that K-9 teams, when available, may be as useful to a critical incident response as other less lethal tools. Despite the length of time it took to complete, the Training analysis failed to discuss the tactical planning issues raised here.

Delay in Review Process

After waiting five months from the time IA completed its investigation until Training completed its review, the Commander's findings memo took another four months to complete. The memo summarized the incident and, like the Training analysis, largely complimented the performance of the involved officers. The memo concludes that the conduct of all involved was within policy. The Police Review Board convened to discuss this incident a month and a half following submission of the Commander's findings and likewise concluded that all officers acted within policy.

In our Second Report, we questioned the value of the Commander's findings memoranda relative to the extensive delays they can create. We recommended that the Bureau consider whether to modify or eliminate the Commander's Memorandum as part of the review process for officer-involved shootings. This incident preceded that report, as well as the United States Department of Justice agreement expressing concerns about the length of the review process for officer-involved shootings. We continue to monitor this issue with the hope that the Bureau will start completing its investigation and review of officer-involved shootings within a more reasonable time frame.

March 6, 2011 ◦ Ralph Turner

On March 6, 2011, two PPB officers were on patrol together and received a radio dispatch notifying them that a woman had reported that her boyfriend, Ralph Turner, threatened to commit suicide using an overdose of pills. The BOEC dispatcher also informed the officers that Mr. Turner was alone in the house and there were two guns in the house that were stored in the garage. They drove to Mr. Turner's residence which had a garage on the ground floor and required entry into the upstairs living quarters via an exterior stairway. The officers arrived there at about the same time as a sergeant. Before approaching the residence, one of the officers tried to call Mr. Turner on the telephone twice but got no answer. The officers and the sergeant began to climb the exterior stairway when Mr. Turner returned the phone call. Mr. Turner's call went unanswered, presumably because the officers and sergeant were about to knock on the door. They opened an outer door to the residence, but the inner metal screen door was locked. The officers asked to speak to Mr. Turner through the screen door and received the reply, "No, but I have a gun." Immediately a gun was fired from inside through the screen door. The officers felt the bullet pass between them. The sergeant and officers retreated from the door and sought cover, each heading in a different direction. The sergeant called in SERT and Crisis Negotiation Team (CNT).

One officer ran into Turner's back yard then over into the neighboring property where he told the neighbors to take cover in the basement and took up an observation position in the house looking out at Mr. Turner's residence. The officer broadcast a shots fired call and warned back up officers en route to approach from a safe angle. He also stated that he had been hit by Mr. Turner's shot, later adding that he had been able to move to safety and did not require a rescue.

Officer Davonne Zentner heard this broadcast and found the second officer who indicated he had been struck by Mr. Turner's original gunfire when she arrived at the scene. Officer Zentner took cover with the officer behind a parked car, she checked him for injuries and found none; then the officer left cover to return to his patrol vehicle to retrieve his AR- 15 rifle. Other officers arrived at the scene and took various perimeter positions in response to guidance broadcast over the radio. Some of the officers stationed themselves behind cars and trees in the area of Brooklyn Park, adjacent to the house and near Officer Zentner. One of those was Officer Parik Singh who took a position behind a tree. Officer Zentner saw Mr. Turner silhouetted in the front window, ducked down then heard three very

loud shots coming from the direction of the window. Mr. Turner had gone into the interior of his house, armed himself with a scoped rifle and fired the shots from his front window, hitting Officer Singh. Officer Zentner fired three or four shots back at the window with her pistol. Officer Singh said over the radio "I've been shot." Nearby officers could see that he was lying on his back with his rifle lying beside him. Officer Singh had been shot once in the torso and could not move to better cover.

Officer Justin Clary arrived and took a position near Officer Zentner, then fired one round at the individual with a rifle. Sergeant Scott Montgomery arrived and determined that most areas in the park afforded inadequate cover except for the bathroom structure. He and Officer Clary and other officers nearby discussed the need to evacuate Officer Singh to get him medical attention, as well as Officer Zentner, because it was apparent that she was in a vulnerable "kill zone." Sergeant Montgomery instructed Officer Clary to "lay down cover fire" at about one round per second so that Officer Zentner and another nearby officer could run to a safer position near the bathroom structure in the park.[12] Officer Clary did so, firing at a patch of concrete below the front window, and Officer Zentner was able to remove herself to better cover without mishap.

Officers established a command post, which was later moved to a safer location when it was observed that this position was still within range of Turner.

Twelve minutes after Mr. Turner fired the first shots and approximately one minute after he shot Officer Singh, an East Precinct sergeant/CNT negotiator who had monitored the incident from the station over the radio was able to get Turner on the telephone. Mr. Turner stated that he had tried to shoot the officers in the legs and that he intended to commit "suicide by cop." The negotiator talked to Mr. Turner about his problems, his girlfriend and his firearms, and assured him that there were alternatives to getting shot by the police.

Mr. Turner agreed to remain seated on the couch in his home and not shoot anymore. While conducting this conversation, the negotiator was being driven to

[12] According to PPB use of force policy, "cover fire" is permissible when it conforms to the following circumstances and definition: "when a member discharges a firearm in a tactical situation to neutralize the use of deadly physical force. Cover fire is not meant to strike a subject but is meant only to prevent subjects from taking action against the police or others…Cover fire can be dangerous and must be used with extreme caution. The Portland Police Bureau expects its members . . . to have considered safety factors such as backdrop and penetration, as well as the effect on the incident dynamics."

the scene by another sergeant. When he arrived, the negotiator sergeant told the captain who had assumed command of the critical incident that he was currently on the phone with Turner. The negotiator then entered the HNT van already at the command post. HNT personnel attempted to monitor and record the cell phone on which the negotiator was conversing. This attempt was unsuccessful, but the negotiator continued to talk with Mr. Turner over his cell phone and to relay the progress of the conversation to the HNT unit. He persuaded Mr. Turner to surrender to the officers outside and gave him instructions on how to walk out the front door with his shirt off, no weapons on him, and no objects in his hands. One hour after the negotiator sergeant had first contacted Mr. Turner by phone, Turner followed the instructions and was arrested outside the house without further incident.

Officers found a scoped rifle, a revolver, and a shotgun inside Mr. Turner's residence. A SERT medic checked Mr. Turner and found no injuries, but determined that he should be transported to the hospital because of a pre-existing medical condition.

The Grand Jury presentation of this incident focused on the actions of Mr. Turner and not on the use of force by police because Mr. Turner was not wounded in the exchange of fire, therefore there was no Grand Jury finding as to the officers' actions. Officer Singh survived the wounds inflicted by Mr. Turner, who was prosecuted for attempted murder and other counts, convicted and sentenced to 35 years in prison.

Timeline of Investigation and Review

3/6/2011	Date of Incident
10/11/2011	Detectives' Investigation completed
3/27/2012	IA Investigation completed
5/10/2012	Training Division Review completed
10/3/2012	Commander's Findings completed
12/5/2012	Police Review Board

Analysis/Issues Presented

Communication Issues

Officers on scene were not consistently broadcasting their shots or other actions. For example, Officers Zentner and Clary shot at Mr. Turner's window shortly after his volley of three shots but failed to broadcast this fact. By contrast, a little later during this critical incident, an uninvolved officer alerted other officers over the radio that the cover fire by Officer Clary were PPB rounds, effectively reducing the possibility that officers would believe they were being fired on by Turner.

Communications by Crisis Negotiation Team (CNT) officers, though effective, were likewise not without issues. Neither SERT nor CNT had a chance to muster before officer Singh was wounded, just 13 minutes after the incident commenced. Efforts were made, nonetheless, to reduce the threat through communication. A CNT Sergeant, monitoring the unfolding radio traffic about the incident, said, "I heard an officer advise that he had been shot. At this point I believed contacting the suspect by telephone may help preoccupy him so that he would not continue shooting at officers."

The CNT sergeant called the first relevant number he could find, expecting to reach Mr. Turner's girlfriend, who was at another location, to ask for a direct number for him. Instead Mr. Turner picked up the phone and the sergeant was plunged into a negotiation with an active shooter without being able to warn or apprise the incident commander or the CNT team on the scene. Perhaps due to the evident urgency, he had not set up electronic monitoring of the call as a precaution. The CNT negotiator sergeant's skill and sensitivity as a negotiator was evident as he established a rapport and gained the cooperation of Mr. Turner. The positive outcome with no further shooting or injury was in large part a direct result of that skill. But the precipitous way in which the negotiation started was far from ideal. Fortunately, the sergeant realized this and took pains to go through the cumbersome process of relaying key facts about the conversation to his CNT colleagues so that the team could be kept abreast of developments. Nevertheless, other SERT officers stated that they were not informed of the status of the negotiations until Turner was about to surrender.

First Supervisors at the Scene Did Not Take Command

When Mr. Turner initially refused to open the door or come out, and then shot at the officers standing on his doorstep, the sergeant with them immediately recognized the situation as a barricaded person and called in SERT and CNT. This standard procedure recognizes the unpredictable nature of a barricaded person's intentions and behavior in these circumstances. It creates an opportunity to slow the incident down and seek cover until specialists with better resources arrive and can develop a plan that will maximize the chances of resolving the incident without injury.

While it was wise for officers to tactically reposition with the intent to wait for SERT, they did so ineffectively here because they did not initially establish a sufficiently wide perimeter, and arriving officers who got there before SERT/CNT unwittingly put themselves into the middle of the problem. When officers hear a radio broadcast that a fellow officer has been hit by an active shooter, experienced supervisors know that the desire to help combat the threat can become overwhelming and may undermine standard levels of regard for officer safety. The geography of the scene, with a house on high ground across the street from the open space of a park offering very little cover, created a particularly dangerous situation for officers rushing in to help. The antidote to these concerns is strong communication and supervision in anticipation of a large number of backup officers arriving at the scene.

The layout of the Turner residence sitting on a second floor high atop surrounding areas gave Mr. Turner significant tactical advantages that higher ground usually provides and made the officers tactical response particularly challenging. The Bureau's own internal evaluations of the incident pointed out that those officers already at the scene needed to broadcast what they knew about geographical areas of potential vulnerability, and supervisors not yet at the scene needed to proactively extract that information so they could have guided officers to a safer approach. The lack of an on-scene supervisor who could exercise control and coordination magnified this problem. The sergeant who had accompanied the two officers to make initial contact with Mr. Turner had to retreat hastily when Mr. Turner fired his first shot and was subsequently pinned down in a poor location. The next sergeant to arrive had been alerted to the first sergeant's predicament but soon found himself under fire from Mr. Turner who was now using a scoped rifle. Neither sergeant issued a clear message to others at or arriving at the scene about who was in charge, and neither determined and broadcast a safe route into the

area. By contrast, when Sgt. Montgomery arrived he was able to assess the dangers and the specific vulnerability of officers on the park side of the house and to arrange for the rescue of a wounded officer as well as those pinned down by exposure to the suspect's vantage point. He also took action to rearrange the perimeter for the protection of officers.

One of the officers who went to the door initially was struck with something that turned out to be shrapnel lodged in his ballistic vest; he took a few minutes to determine that he was not seriously injured and not in need of rescue. The affirmation that this officer did not have a medical emergency requiring his immediate evacuation provided an unexploited opportunity for on-scene supervisors to slow down the backup response and coordinate a sound plan. An opportunity to have early on-scene supervision was lost when a second sergeant arrived at the scene and took a perimeter position behind a car by the park. When Mr. Turner started shooting again, the sergeant realized he was vulnerable and could not safely move to better cover. He spent the rest of the incident – including the injury and rescue of Officer Singh, the extraction of Officer Zentner, and the use of cover fire –pinned down as a potential target instead of being able to assist with supervision of the operation.

Quality of Investigation and Review

Internal Affairs Division Investigation

The investigators did a thorough job of teasing out the details of tactical behavior while remaining neutral. In the interview of Officer Zentner, for instance, the investigator established that the officer observed Mr. Turner in the window, believed that he was shooting at her and believed that a round or debris flew by her head and so "shot…in direct response to his shots, and I was trying to get him to stop firing." But when she returned fire, she said she could not see Mr. Turner.

The IA report explained that investigators, in their interviews, had delved into questions of the supervision deficiencies during the period before SERT arrived. However, IA also noted that conclusions about the issue would be handled by the Training Division, which Training did do at length. Less understandable is IA's decision not to interview the CNT negotiator or to pursue the question of whether telephone contact with Mr. Turner could have been made any earlier than the somewhat accidental moment when contact did commence. It would have been

more prudent to explore all relevant actions and decisions by patrol personnel as well as special units, such as SERT/CNT.

Officer Singh was not interviewed by IA, probably because he did not fire a weapon or order the use of deadly force. Nevertheless, his perspective, the information available to him, and his decision-making process before being shot, are decidedly relevant to the analysis of the incident and to aid efforts to reduce similar officer safety problems in the future. For that, executives and Training Division had to rely on the Detectives interview. This was a less than optimal approach because the criminal investigation performed by detectives after a shooting did not focus on tactical decision making.

While over one and a half years passed before the Bureau was able to complete its investigations and internal evaluations of the incident, it is important to note that a large portion of that delay was the result of the District Attorney's request that the formal review be held in abeyance until the prosecution of Mr. Turner was resolved. This delayed the Bureau's determination of the important lessons of this major incident.

Training Division Review

The media treatment of this incident depicted a conspicuously dramatic and frightening incident that reminded the public of how dangerous police work can be. Within the Bureau, it is fair to infer that this was a deeply perturbing incident because of widespread acknowledgment that it could have easily resulted in additional injury or loss of life. Often, the death or wounding of a fellow officer inhibits self-analysis. We have observed many instances in other law enforcement agencies where an incident in which an officer is injured engenders superficial after-action analysis and a palpable reluctance to explore even obvious tactical or supervisorial deficiencies. This was not the case with the Bureau's analysis of this incident.

The Training review appropriately recognized the positive aspects of the involved officers' performance, but it also took a clear-eyed look at the tactical deficiencies and miscalculations in the first few minutes of the incident and was frank in its critique. It focused its harshest analysis on the actions of the sergeants who played important roles in the unfolding scene but who failed to address the vital issue of who was in charge. The Training review further addressed the continuing communication problems even after SERT arrived on the scene. It pointed out that SERT officers who replaced patrol officers in the perimeter positions did not

receive any updates on the CNT negotiations, which went on for an hour until Mr. Turner was about to surrender. Training also criticized the initial significant miscalculation about the physical areas of vulnerability and the danger Mr. Turner presented, as evidenced by the mid-incident relocation of the command post.

Despite the penetrating criticism of the sergeants' performance during this incident, the Review Board did not recommend remedial training for those involved, a briefing to all patrol sergeants, or other corrective action. This appears to be a lost opportunity for the Bureau to follow through on its own candid critique.

Because of the nature of this incident, Training's recommendations for clearer guidelines and training about scene command and communication at and while approaching the scene relate to officer safety rather than constitutional policing. These are nevertheless matters in which the public should take a strong interest. Experience shows us that neglecting principles of officer safety can more easily lead to undisciplined use of force. When officers in the field neglect to communicate clearly with one another and fail to utilize safe tactics, then unexpected circumstances are more likely to give rise to fear and panic and poor use of force decision making. That outcome did not happen in this case, but the Training Analysis implicitly recognizes the need to take this potential very seriously.

July 10, 2011 ◦ Darris Johnson

Officers Justin Thurman and Zachary Zelinka were on routine patrol on July 10, 2011 when, at around 4:00 a.m., they observed a 2000 Cadillac Seville driving without tail lights. They conducted a traffic stop during which they learned that the driver, a female African American, did not have insurance. There were three African-American male passengers in the car, and officers observed the passenger seated behind the driver – Darris Eugene Johnson – was not wearing a seat belt. Officer Thurman intended to cite Mr. Johnson for the seat belt violation and asked for identification. Mr. Johnson said he did not have his ID with him and gave the officers a different name and birthdate. The officers became suspicious because he hesitated and stumbled a bit when trying to recall his birthdate. Officer Lonn Sweeney, a K-9 officer, was in the area and arrived to assist. Officers decided to impound the vehicle because of the driver's uninsured status, and called for additional backup to assist with the handling of the four occupants. All four individuals got out of the vehicle and Officer Zelinka began to do an inventory search of the car while Officer Thurman prepared citations. Officer Zelinka found an Oregon ID card wedged into the backseat that appeared to belong to the passenger and bore the name Darris Johnson. Zelinka walked back to the patrol car to communicate this information to Thurman, and the officers decided to arrest Mr. Johnson for providing false information. They did not know at this time that Mr. Johnson had an outstanding felony parole arrest warrant.

Officer Zelinka walked back to the subject vehicle while Officer Thurman stayed at the patrol car to continue his background investigation. As Officer Zelinka walked past Mr. Johnson, he told him he was not free to leave. Shortly after, Officer Thurman approached Mr. Johnson and told him to put his hands behind his back, intending to handcuff and search him. Mr. Johnson turned and ran from the scene. All three officers pursued, with Officers Zelinka and Sweeney out in front of Officer Thurman, as Mr. Johnson ran at a "dead sprint." Officer Sweeney used a remote control to open his patrol car and let his dog out to join the pursuit. Officers' descriptions of the foot pursuit vary, but it appears to have lasted only a short time before officers began focusing on setting a perimeter to contain the fleeing individual. Mr. Johnson followed a route that had him climb or jump over three fences before he lay down in a residential backyard. Officer Zelinka followed him over the first – a four-foot chain-link fence – but did not continue his pursuit. From his vantage point peeking over the second fence, Officer Zelinka saw that Mr. Johnson had climbed the third fence but he could not see beyond that. Other officers eventually closed in from their perimeter positions

and found Mr. Johnson lying in the grass. Officer Sweeney's canine was on leash and played no role in the apprehension of Mr. Johnson.

Officers Sweeney, Zelinka, and three others who had arrived as backup took Mr. Johnson into custody without any fight or use of force. From the time that officers broadcast they were in foot pursuit and the time they had Mr. Johnson in custody, nearly 20 minutes had elapsed. Mr. Johnson was handcuffed and stood up on his own, but then complained to officers that he could not breathe or was having trouble breathing. Officers Thurman and Zelinka said that he seemed fine, though, and was moving around and coherent and appeared to be breathing normally. They assumed he was out of breath because he had run from them, and noted the officers involved in the pursuit were also out of breath from exertion. Mr. Johnson walked 75 – 100 yards to a patrol car on his own and, while he continued to complain that he could not breathe, he did not appear to officers to be having any actual trouble breathing.

Mr. Johnson cooperated while officers searched him and placed him into the back of other officers' patrol car, but, according to Officer Zelinka, he began kicking and flailing inside the car. Officer Zelinka could hear him yelling but could not understand what he was saying. Neither Detectives nor IA interviewed those transporting officers. They drove Mr. Johnson back to the location of the original traffic stop while Officers Zelinka and Thurman walked the distance. They then transferred Mr. Johnson to Officers Zelinka's and Thurman's car to be transported to jail and booked into custody. Mr. Johnson continued to be uncooperative as they tried to move him into the back seat of the second patrol car. He refused to get out of the first car, and officers had to pull him out, causing him to fall to the ground. He then got up and walked to Officers Zelinka's and Thurman's car, where he sat down but refused to put his feet in the car. Officer Zelinka pulled him into the back seat while other officers lifted his feet in. Throughout this time, he continued to say that he could not breathe. Because Mr. Johnson was talking with them, appeared not to gasp for breath and to be functioning normally, officers viewed these complaints as a type of "passive resistance," saying it is common for arrestees to feign some type of injury in order to delay their trip to jail.

Officer Thurman began driving the patrol car to East Precinct while Officer Zelinka monitored Mr. Johnson from his vantage point in the front seat. Within a few moments of leaving the scene, it appeared to Officer Zelinka that Mr. Johnson was pretending to sleep, which Officer Zelinka described as a common

thing for people to do. Officer Thurman stopped the car, and Officer Zelinka got out, opened the back door, and shook Mr. Johnson's chin, causing him to rouse slightly and mumble something incomprehensible. His breathing seemed normal. This confirmed Officer Zelinka's belief that Mr. Johnson was merely pretending to sleep, and they continued the trip to East Precinct.

Officer Zelinka said he could hear Mr. Johnson breathing – almost snoring – during the drive, and became alarmed when that sound ceased. Officer Thurman again pulled over. Both officers got out to check on Mr. Johnson, whom they found unresponsive and without a pulse. They called for paramedics and a sergeant, pulled Mr. Johnson out of the car, and put Mr. Johnson on his side in an attempt to position him to ease his breathing. When a sergeant arrived, he instructed them to begin CPR. Officer Thurman and a cover officer began CPR while Officer Zelinka attempted to locate a breathing mask. Paramedics arrived approximately three minutes later and took over lifesaving measures. They transported Mr. Johnson to the hospital, where he was pronounced dead approximately two hours after his arrival. The Medical Examiner determined the cause of death to be cardiac dysrhythmia as a result of an enlarged heart and methamphetamine intoxication. The stress of his flight from the officers followed by his restraint was also a factor in Mr. Johnson's death.

The District Attorney did not convene a grand jury to consider this case, but closed it with a memorandum concluding that there was no improper conduct by involved officers that warranted criminal charges.

Timeline of Investigation and Review

7/10/2011	Date of Incident
7/29/2011	DA memo finding no improper conduct
11/4/2011	IA investigation began
12/30/2011	IA Investigation completed
3/29/2012	Training Analysis completed
6/27/2012	Commander's Findings completed
8/15/2012	Police Review Board

Analysis/Issues Presented

Deployment of Canine on Fleeing Misdemeanor Suspect

The K-9 officer who responded as cover for the initial traffic stop released his dog when Mr. Johnson fled. He sent the dog with a command to bite the subject in the belief Mr. Johnson was attempting to escape police custody. Because Mr. Johnson jumped or climbed over several fences, the dog did not catch or bite Mr. Johnson and was leashed by his handler prior to the officers taking Mr. Johnson into custody. Because the dog did not make contact with Mr. Johnson, the Police Review Board did not make any findings as to whether this use of the canine was in policy, though the facts surrounding Officer Sweeney's release of the dog were explored in the investigation and Training analysis.

The Standard Operating Procedures (SOP) followed by the PPB Canine Unit provide that a police canine may be used: "To locate, apprehend, or control suspects reasonably believed to be involved in a crime. . . ." or "[t]o apprehend a fleeing criminal suspect when the canine officer reasonably believes that probable cause exists to arrest a suspect for a crime." Officer Sweeney's use of the dog here was within the parameters of this policy, but points to a problem with that policy, in that it allows deployment of a canine to bite a person wanted for any crime, including nonviolent misdemeanors. Recognizing the seriousness of the injuries that dogs can inflict, as well as the history and symbolism of the use of police dogs, other urban law enforcement agencies limit their deployment to the apprehension of individuals suspected of serious or violent felonies.

If the canine had caught and bit Mr. Johnson as he fled, the bite would have been evaluated as a use of force according to the PPB policies guiding the use of non-lethal weapons. This points to an ambiguity with the current SOPs. While canine handlers are permitted to deploy a dog to apprehend and bite an individual wanted for any crime, the determination of whether a particular use of force is constitutionally reasonable depends, in part, on the severity of the crime at issue. *Graham v. Connor*, 490 U.S. 386, 396 (1989). Had the dog in this incident caught Mr. Johnson as he fled and inflicted a serious injury – particularly likely when a person is fleeing and the dog bite is more likely to tear skin and muscle rather than puncture it – it is not clear that this use of force would have passed constitutional muster. See *Miller v. Clark County*, 340 F.3d 959 (9th Cir. 2003) (describing a dog bite as "considerable" force but not excessive force prohibited by the Fourth Amendment where the individual was wanted for a felony, may have been armed, and was hiding in a heavily wooded area).

Recommendation 15: The Bureau should consider revising its Canine Standard Operating Procedures to limit the deployment of canines to the apprehension of subjects suspected of committing serious or violent felonies.

Decision to Transport Subject

The officers involved in the pursuit and apprehension of Mr. Johnson apparently never seriously considered calling paramedics to evaluate Mr. Johnson's claimed inability to breathe prior to transporting him in their radio car. They attributed any shortness of breath to him having run away from them, saying that it is common for detainees to say they cannot breathe after having fled from police. Officers stated that despite his claims, Mr. Johnson appeared to be fine – he could talk coherently and was able to walk on his own. Officers also suggested that detainees sometimes claim they are having some medical issue in an attempt to avoid being immediately taken into custody.

Following the in-custody death of James Chasse in 2006, the PPB implemented a new policy regarding the transport of injured or ill subjects to provide clearer guidance to officers confronting the decision about when to transport subjects to jail and when to call EMS personnel. PPB Directive 630.45: Emergency Medical Custody Transports states:

> Members will not transport subjects who appear to be seriously injured, seriously ill, or unconscious unless an on-scene evaluation by EMS determines the subject is cleared for officer transport. This includes, but is not limited to any subject who:
>
> . . .
>
> c. Displays respiratory difficulty, including but not limited to, shortness of breath, extreme wheezing, etc.

There was no discussion in the investigative or review materials about whether officers had complied with this directive. If Mr. Johnson was displaying shortness of breath, he should have been evaluated by EMS personnel. Unfortunately, neither the Detectives' nor IA investigations clearly establish whether Mr. Johnson was actually experiencing difficulty breathing or whether he was displaying objective signs of medical distress and merely claiming to be unable to breathe. The officers' accounts vacillate between acknowledging a

shortness of breath but dismissing it as an effect of the foot pursuit or dismissing Mr. Johnson's claims entirely because he otherwise seemed fine. Either way, the ultimate outcome here makes it clear that officers should have called EMS. The Bureau should evaluate how it trains its officers on the requirements of Directive 630.45 to emphasize the importance of taking seriously subjects' claims of medical distress. The potential inconvenience of making what turns out to be an unnecessary call to EMS personnel is preferable to having another subject die in the back seat of a patrol car. Officers should be instructed – by policy and in training – to err on the side of calling EMS rather than being dismissive of subjects' complaints prior to transporting them.

Following this incident, Training Division recommended that PPB Directive 630.45 be amended to add an additional subsection, to include in the list of those who must be cleared for officer transport by EMS and subject who:

> f. Appears or admits to being under the influence of cocaine or amphetamine substances and has been involved in a prolonged physical altercation or exertion.

Training further recommended additional language that would require officers to ask subjects whether they are under the influence of cocaine or amphetamines. These recommendations were consistent with statements made by the Medical Examiner during his review of this incident and would only slightly expand requirements in existing policy, which requires officers to get EMS clearance before transporting anyone who:

> e. Appears to be extremely intoxicated and/or under the influence of drugs in conjunction with any of the above symptoms and has been involved in a prolonged physical altercation.

While the requirement that officers ask arrestees whether they are under the influence may be a useful addition to existing policy, given that the policy already contained language applicable to this situation – subsection (c), dealing with respiratory difficulty – it is curious that the Training analysis focused on recommending a new provision rather than provide a critique based on the existing language.

Recommendation 16: The Bureau should consider revising its policy and/or training to require officers to consult emergency medical response personnel prior to transporting subjects who claim to be having difficulty breathing or to be in some sort of medical distress.

Failure to Challenge Officers' Key Assertion

Throughout their interviews and written report, involved officers repeatedly stated they disregarded Johnson's heavy breathing and claimed difficulty breathing because it was normal for someone who had just run from police. Some also stated they were out of breath from the chase, too. But the timeline in the case materials shows that nearly 20 minutes elapsed between the time officers announced they were in foot pursuit until they had Mr. Johnson in custody. The foot pursuit covered 650 feet and three fences but was followed by a period of containment and search before officers discovered Mr. Johnson lying in a backyard and took him into custody, 19 minutes and 34 seconds after the pursuit began. Officer Zelinka described himself as "pretty quick" but said Johnson was running so fast he couldn't really catch up with him. Johnson probably was running for a minute or less. The officers ran a shorter distance. All of them likely had at least 18 minutes to recover from their run prior to their encounter and Mr. Johnson's claim that he could not breathe. Given this time span, it seems unlikely that anyone should have still been out of breath as a result of the run. Nonetheless, neither Detectives nor IA investigators questioned the officers regarding the timeline or challenged the officers' assertion that they were out of breath when they took Mr. Johnson into custody. If officers themselves had fully recovered from their run, their dismissal of Mr. Johnson's breathing difficulties would have been less reasonable.

Tactical Issues Relating to Traffic Stop

Officer Zelinka located Mr. Johnson's Oregon State ID in the backseat of the subject vehicle and delivered it to Officer Thurman in the patrol vehicle. Officer Thurman made the decision to arrest Mr. Johnson at that time for providing false information to an officer. He approached Mr. Johnson on his own and was attempting to take him into custody when he fled. It was only later, when officers were searching for Mr. Johnson within their perimeter, that Officer Thurman requested that BOEC run the subject's name and then learned he had an outstanding arresting warrant stemming from a parole violation relating to a narcotics trafficking conviction. It is not clear from the investigative materials why officers did not request this information prior to attempting to arrest Mr.

Johnson at the scene of the original traffic stop. The failure to do so compromised officer safety because officers did not know anything about the subject at the time they confronted him other than the suspicion he had some reason for not wanting the police to know his real identity. Taking the time to wait for the return from BOEC would have given them valuable insight into Mr. Johnson's background and the risks he presented. For example, had Mr. Johnson been wanted for a murder charge or for assaulting a police officer, Officer Thurman likely would have thought differently about attempting to handcuff him without assistance. Unfortunately, neither Detectives nor IA investigators questioned the officers about any reasons they may have had for not learning about Mr. Johnson's warrant status before confronting him to take him into custody. The Training analysis also did not address this issue.

The Training Division Review, however, did thoroughly examine some tactical issues involving the traffic stop, including:

- Officer Thurman's appropriate decision to call for backup prior to getting the four occupants out of the patrol car;
- The mistake Officer Zelinka made in signaling to Mr. Johnson that he was going to be arrested;
- Officer Thurman's decision to approach Johnson alone to cuff him without telling the others or having one of them stand by to discourage Johnson to fight or run.

Neither the Commander's Memorandum nor the Review Board noted or addressed through remedial action the two tactical mistakes identified by the Training Division Review. It is incumbent upon the Bureau to explicitly address all issues by Training during its review process.

Quality of Investigation and Review

Key Witness Officers Not Interviewed

Both Detectives and IA investigators focused primarily on the decision to transport the subject in a radio car and the response to Mr. Johnson's medical distress. Of the officers involved in the apprehension of Mr. Johnson, Detectives interviewed only Officers Thurman and Zelinka. They did not interview Officer Sweeney, who participated in the pursuit and was present when Mr. Johnson was

taken into custody, or the three officers who assisted in handcuffing Mr. Johnson and transporting him back to the sight of the original traffic stop to be transferred to Officers Thurman and Zelinka's patrol car. Nor did they interview the sergeant who was at the scene. All of these individuals produced written reports on the date of the incident. Each wrote he had heard Mr. Johnson complain about not being able to breathe and gave the same general explanation for why this did not cause any alarm.

Interviews of the two officers who transported Mr. Johnson back to the original stop location would have been particularly important to explore issues surrounding Mr. Johnson's resistance to arrest. Officer Zelinka stated in his interview with Detectives that Mr. Johnson was yelling and flailing and kicking at the divider in those officers' patrol car. Yet neither of these officers noted this behavior in their written reports. The driver stated he heard Mr. Johnson moving around in the backseat, but did not hear any comments, as he remained focused on driving. The passenger officer described some difficulties getting Mr. Johnson into the car but did not mention any aggressive or resistive behavior during the short drive. When Officer Zelinka commented on Mr. Johnson's kicking and flailing during his interview with Detectives, the interviewer seemed surprised to hear that Mr. Johnson had been kicking at the patrol car, but conducted no follow up on this point.

IA investigators interviewed Officers Thurman, Zelinka, and Sweeney. Uncharacteristic compared to other critical incident investigations we have reviewed, the IA interviews of involved officers were cursory and largely reiterated what Detectives covered in their interviews. Like Detectives, IA also did not interview the other officers who had been involved in taking Mr. Johnson into custody.

This incident raised broader issues than the question of whether officers had any criminal liability for Mr. Johnson's death. In particular, as noted above, investigators should have been examining the question of whether officers violated the Custody Transport Directive by transporting Mr. Johnson in their radio cars without an on-scene evaluation by EMS. On this issue, gaining the perspective of all the officers who heard Mr. Johnson complain about not being able to breathe and who observed his actions and demeanor would have been valuable to the administrative investigation.

Recommendation 17: The Bureau should consider revising its investigative protocols to require that investigators interview all witness officers in any in-custody death investigation.

Failure to Address Foot Pursuit Issues

Both Detectives and IA investigators focused primarily on the officers' legal justification for detaining and chasing Mr. Johnson and posed few significant questions regarding the details of the pursuit. It was difficult to tell from the investigative materials the route each officer ran and in what sequence, to what extent they communicated with each other, and whether and when they broadcast information about their pursuit and containment. The information we can glean from the officers' statements raises some questions about the decision to pursue as well as the way in which officers conducted the pursuit.

For example, three out of four officers conducting the traffic stop ran after Mr. Johnson, leaving one officer behind with the three other occupants of the vehicle. Also, Officer Zelinka was ahead of and ran further than other officers, and he was the only one to follow the subject over at least one fence, but we do not know whether other officers maintained visual sight of Officer Zelinka or what paths they took. In addition, it does not seem that officers were communicating or pursuing, at least initially, in any sort of coordinated way. Officer Sweeney, for example, did not know that Officer Thurman was even engaged in the pursuit. Officer Sweeney's decision to introduce the dog into the pursuit also raised potential issues, with both Officers Zelinka and Thurman noting that they changed their pace and direction in order to avoid having the dog mistake them for the fleeing individual and chase and bite them.

The pursuit quickly transitioned to an effort to set a perimeter to contain the subject and then to search for him within the perimeter. Officers located Mr. Johnson roughly 20 minutes after the pursuit began. Because the officers had probable cause to arrest Mr. Johnson, the Commander's memo and the Police Review Board found the pursuit to be within policy. Presumably because the chase ended quickly and without a shooting or force incident or any immediate connection to Mr. Johnson's death, the Bureau's reviewers did not critically discuss the tactical issues surrounding the foot pursuit, including the decision to pursue while leaving one officer behind with three subjects; the possible consequences of Officer Zelinka's decision to pursue ahead of the others; communication between officers and with dispatch (or lack thereof); or the wisdom of the decision to deploy the canine.

In our Second Report, we discussed some of these foot pursuit issues and recommended that the Bureau review its foot pursuit policy to consider some revisions, including prohibiting officers from splitting from their partners and making mandatory radio communication at the beginning of a pursuit. The Bureau was hesitant to introduce mandates into its policy. We will not belabor the issue here. The broader issue raised in this incident is the Bureau's failure to look critically at potential issues with the foot pursuit. Just because the pursuit did not lead directly to the unfortunate outcome here does not mean the problems are not worthy of exploration or ripe for possible solutions. Indeed, a progressive police agency should take advantage of these situations to proactively address potentially problematic scenarios.

Recommendation 18: The Bureau's Detectives and IA investigators and its reviewers in the Training Division, Executive Staff, and Police Review Board should be reminded to address all potential policy violations and tactical issues, even where those issues did not directly lead to the outcome in the given incident.

SECTION TWO

Common Themes and Issues

Confronting Subjects at a Doorway

In six of the eight shootings we review in this report, PPB officers confronted and fired their weapons at subjects at or near a doorway of a residential dwelling. In just one of these – Turpin – the officer was inside the residence and shot out at the subject. In one – Coady – officers were serving a search warrant when they opened the door to a backyard shed and shot at Mr. Coady following a brief exchange. In all of the others – Bolen, Carter, Ferguson, and Turner – the officers were responding to calls for service concerning some disturbing or threatening behavior inside the residence and confronted the subjects either at the threshold or just outside the doorway.

It is difficult to define a set of rules or "best practices" that officers should engage in when confronting an individual at his own door because the circumstances under which the officers may be at the door are so varied. In Carter, officers felt the obligation to confront a person who had allegedly pointed a gun at a young girl before retreating into his apartment. In Bolen, officers believed – erroneously, it turned out – that the subject was assaulting his girlfriend inside his home. Officers who knocked unannounced on Mr. Ferguson's door stepped into a dispute between neighbors. And in the incident involving Mr. Turner, officers

were performing a welfare check in response to a call from the subject's girlfriend that he had threatened to commit suicide by overdosing on pills. One thing all had in common is that officers had some information suggesting the subjects had ready access to guns.

Officers who most effectively resolve situations originating at a doorway are those who create a plan with their fellow officers prior to engaging a subject. The general view that officers should take their time to coordinate and formulate a plan, when the situation permits, is emphasized in PPB training.

Officers who confronted Mr. Carter at the door of his apartment, led by a sergeant, followed this training – they took the time to consider various options, made several attempts to contact Mr. Carter by phone, and evacuated the adjacent apartment before knocking on his door while tactically positioned to address an anticipated threat. By contrast, the officers who confronted Mr. Bolen did no planning before they forced entry into his townhouse. They made little effort to confirm reports that there was a woman inside who may be in danger, and because of the perceived exigency, they did not wait for a sergeant to arrive. In the end, an officer armed with a rifle thought he was responding as long cover but actually participated in the entry.

Before knocking unannounced on Mr. Ferguson's door to instruct him to leave his neighbor alone, officers did not discuss the fact that he reportedly had a gun days earlier nor did they develop a plan for dealing with him should he again be armed. The situation officers confronted when they knocked on Mr. Turner's door demonstrates the unpredictability of these scenarios – approaching to check on an individual who threatened suicide by overdose, officers faced immediate gunfire when Mr. Turner answered the door. While it is unlikely that pre-planning could have prevented this response from Mr. Turner, the other doorway cases we examine in this report demonstrate well the importance of officers slowing their response to strategize and plan for various possible outcomes.

Issues involving lack of planning and communication are often identified during the Bureau's shooting review process. However, the Bureau has a less exemplary track record in developing a corrective action plan to address planning and communication issues that are identified. For example, as noted in this report, while the Review Board in Bolen recommended that Training create a video based on the incident to emphasize the need for better communication and planning, such a video was never developed. In the other shootings, there is scant documentary evidence to establish that issues identified during the Bureau's

review were fully exported to the involved officers through individualized briefings and feedback, or more globally to the Bureau's line officers. On another track, following the 2010 shooting of Craig Boehler, the Training Review recommended that BOEC dispatchers should begin to receive additional training similar to the critical incident management class that the Bureau provides to its supervisors. The Bureau was unable to find documentation confirming any dialogue between the PPB and BOEC in regards to follow through on this issue. Going forward, the Bureau should ensure that issues identified during its shooting reviews are more fully and comprehensively addressed on both a micro and macro level through focused feedback and training.

Delays in Providing Medical Attention to Injured Subjects

Others and we have commented in the past regarding the length of time that it has taken for persons shot by Bureau officers to receive medical attention. As we have noted in previous reports, after the Campbell shooting, the Bureau endeavored to address this issue by placing ballistic shields in patrol cars so that officers could more readily approach individuals who may have been armed and get them more timely medical attention.

In this report, we noted three additional instances of persons being shot and resulting time delays before they received medical attention, two incidents predating and one after the Campbell shooting. In the Bolen shooting, officers waited 48 minutes after they shot Mr. Bolen and exited the house until SERT arrived and reentered to find Mr. Bolen deceased. After a PPB officer fired at Mr. Coady and then heard Mr. Coady fire one shot, it took SERT officers 84 minutes to arrive and approach the injured subject to learn that he had shot himself and was dead. In the more recent Ferguson shooting, it again took 84 minutes from the time that shots were fired before a Bureau officer made entry to find Mr. Ferguson deceased. The Ferguson incident, in particular, is evidence that the issue of whether emergency care is being provided in a sufficiently timely fashion has not gone away, even after the ameliorative steps taken following the shooting of Mr. Campbell.

Delays in Review Process

Our reports have repeatedly noted delays in the investigation and review process for officer-involved shootings and in-custody deaths. In fact, it is more often than not that the review has extended over a year. With each additional shooting or in-custody death that we review, we recognize the delays from the date of incident to time of completion have been endemic. The following table indicates the completion time of the cases we have reviewed to date:

Critical Incident / Subject's Name	Date of Incident	Length of Time to Review Board
Perez	3/28/2004	8 months
Vaida	10/12/2005	13 months
Gwerder	11/4/2005	18 months
Young	1/4/2006	13 months
Grant	3/20/2006	16 months
Goins	7/19/2006	12 months
Suran	8/28/2006	20 months
Hughes	11/12/2006	23 months
Carter	12/28/2006	14 months
Bolen	5/22/2007	16 months
Stewart	8/20/2007	15 months
Turpin	10/5/2007	15 months
Spoor	5/13/2008	17 months
Coady	5/15/2008	13 months
Lovaina-Bermudez	8/24/2008	8 months
Campbell	1/29/2010	7 months
Collins	3/22/2010	14 months
Otis	5/12/2010	16 months
Boehler	11/23/2010	19 months
Ferguson	12/17/2010	13 months
Lagozzino	12/27/2010	15 months
Turner	3/6/2011	21 months
Johnson	7/10/2011	13 months

The delays in the review process create obvious drawbacks to timely identification of issues and accountability. During the pendency of the review, the Bureau is not able to take decisive action regarding performance of its officers that may have violated directives. Moreover, the Bureau's ability to take additional individual or corrective action is limited until all the facts have been investigated and the issues identified and vetted by the Review Board, with recommendations to the Chief. If there is to be accountability and feedback to involved officers and other Bureau members, in fairness and consistent with principles of accountability, the investigation and review process should not extend over such long periods of time.

While the length of time for investigation and review is somewhat explained by the various layers and vigor of the Bureau's investigative and review process, there always seem to be unexplained gaps of inactivity when memoranda are being prepared or Review Board meetings are due to be scheduled. We have previously noted that similar concerns were registered by the United States Department of Justice in its September 2012 findings letter about the length of the review and investigation process for the application of deadly force. Because our review has yet to examine incidents that post-date that letter, we are hopeful that we will see a compressed time frame for investigation and review as our work with the City and the Bureau proceeds.

We have previously suggested that one option deserving consideration that would shorten the time period of review is to eliminate or significantly modify the requirement that the Commander prepare a memorandum detailing his or her findings regarding officers' performance following an officer-involved shooting. With some exceptions, we have not found the substance of those findings particularly insightful and perhaps they are not worth the additional time in the process that their creation requires. For that reason, we repeat that recommendation here.

Recently, the Bureau worked to modify the Commander's Finding Memorandum in the hope that the change will shorten the timelines of investigation and review.

Recommendation 19: The Bureau should consider whether to modify or eliminate the Commander's Memorandum as part of the review process for officer-involved shootings and in-custody deaths.

Reliance on Training Division Reviews

One of the positive features of the Bureau's review process is the requirement that a Training Division Review be prepared for every officer-involved shooting and in-custody death. This analysis is designed to synthesize information collected from the investigation and identify tactical decision-making issues for the Review Board to consider. In the past, we have commented favorably on the level of detail in the analysis, as well as the candor in identifying issues and detailing officer performance. For example, the 55-page Training Division Review prepared for the Campbell shooting ranks as one of the most detailed and sophisticated training analyses we have seen in relation to a critical incident.

That being said, we have begun to question whether the Review Board relies too heavily on the written work of its training experts in identifying issues arising out of the shooting. The Board is comprised of other attendees with a wealth of experience identifying and considering issues of tactical decision making, supervisory issues, equipment issues, practices, policies, protocols, and pre- and post-incident issues. However, with the possible exception of the Commander's Memorandum, we have seen no documented evidence that the issues addressed at the Board hearing push beyond the bounds of those raised by the Training analysis. The Bureau should explore ways to encourage other stakeholders to raise issues from different perspectives after the Training analysis has been received but either prior to or at the Board meeting. We are also interested to learn more about whether the conclusions reached by Training personnel are ever challenged by other attendees and we will be examining that dynamic going forward.

One area that does not seem to result in discussion at the Board hearing is an assessment of the internal investigations and any input for improvement. While our reports have routinely identified issues and challenges regarding the investigation phase, that part of the process is not featured in the Training Division Reviews nor apparently significantly addressed at the Board hearings. To the Bureau's credit, we have observed some effective internal supervision by internal investigative supervisors who have stepped in before the investigation has been completed and requested additional work from investigators. However, we have not seen such an assessment after the investigations are completed as being a key responsibility of the Review Board.

Recommendation 20: The Bureau should consider whether mechanisms or orientation should be revised to increase stakeholder involvement in identifying and resolving issues worthy of discussion for the Review Board.

Holding Officers Accountable Through Discipline and Training

While we have commented favorably on how the Training Division Reviews provide a framework for identification of tactical decision making, we have now reviewed sufficient numbers of incidents to consider whether the Bureau has sufficiently taken its officers to task for decision making that is not consistent with training and organizational expectations. First, as we have noted in this report and in our two prior reports, not all potentially questionable tactical decision making is identified by the Bureau's current review process. While two of the Training analyses have been comprehensive, incisive, and have ultimately led to the City's initial decision to terminate the involved officers, in both cases (the Young and Campbell shootings) the discharge decisions were overturned during the appeal process. As we continue to review Portland shootings, we are left to consider whether those two cases are outliers and whether the Bureau should broaden its willingness to identify clear policy violations and impose discipline or other corrective actions.

As a foundation to any consideration of the Bureau's pattern of corrective action following critical incidents, it is important to emphasize two principles: (1) Discipline is a normal and necessary part of management's responsibility in a police organization to speak forcefully and consistently to its sworn employees; (2) Corrective action should be broadly defined to include training, equipment and policy changes, focused debriefings, and, where appropriate, discipline.

Some law enforcement agencies rigorously examine the performance of involved officers and supervisors. If they find one significant tactical decision or a combination of several less significant decisions that were both inconsistent with agency policies or training and principles of officer safety, they impose discipline for those performance issues. While the level of discipline for such performance issues is usually low, the imposition of discipline sends a strong message about the potential connection between officer decisions inconsistent with principles of officer safety and situations that may cause the officer to feel the need to use

deadly force. Accordingly, such shortcomings – failure to formulate a plan before engaging a suspect, failure to broadcast critical information, pursuing and attempting to apprehend an armed suspect on foot, failure to wait for backup before engaging directly with the suspect, and supervisors jumping into the action rather than standing back and supervising – are all decisions that are not consistent with principles of officer safety and prudent tactical decision making. In our previous reports, we have identified occasions when these issues may or may not have been identified by the Review Board, but rarely in Portland have such decisions led to either discipline or other targeted corrective action.

One exception to this pattern noted in this report resulted from the Coady shooting. Formal discipline was imposed on a sergeant who was instrumental in the planning and execution of a search warrant. This corrective action was notable because it was imposed upon a field supervisor for deviating from an operations plan and for failing to inform his teammates about his independent actions that could potentially put them at risk. Poor communications and officer safety issues were likewise at the heart of tactical shortcomings identified, for instance in the Bolen, Johnson, and Turner shootings reviewed in this report. No discipline or formal corrective action emanated from those cases.

During their review processes of deadly force incidents, other agencies have their Review Boards routinely ask themselves not only whether the decision to use deadly force was in policy but also whether officer performance was so below the agencies' expectations that it demands remedial action. This is consistent with the broadly accepted understanding that tactical decisions and judgments have consequences in the field and will often determine the need or perceived need to use force. We suggest the Bureau consider refining its Review Board protocols so that questions about officers' tactical decisions and performance leading up to the use of force are routinely asked during its deliberations.

Recommendation 21: The Bureau should consider whether the Review Board process focuses sufficiently on officer performance, not only with regard to the decisions to use deadly force, but also on the question of whether tactical decision making merits remediation through discipline or other alternative means. The Bureau should consider developing practices or protocols to ensure that the Review Board addresses issues and renders judgment regarding tactical performance and decision making.

SECTION THREE

Recommendations

1 *The Bureau should examine its current processes to determine whether there is a sufficiently robust system ensuring that recommendations emanating from its reviews of use of deadly force incidents are implemented. (p.18)*

2 *The Bureau should consider adopting protocols where the Police Review Board routinely revisits past reviews to obtain feedback on the implementation and effectiveness of its recommendations. (p.18)*

3 *The Bureau should again consider whether it is beneficial to the interests of the City to have the East County Major Crimes Task Force involved in investigations of PPB officer-involved shootings. (p.22)*

4 *If there is uncertainty regarding whether PPB can issues communication restriction orders to officers involved in off-duty shooting incidents unless an Internal Affairs investigation is opened, the Bureau should revise its policies so that communication restriction orders are issued in all shootings involving PPB personnel, regardless of whether the shooting is on or off duty. (p.32)*

5 *The Bureau should ensure that policy and training convey a clear message that the option to tactically reposition, contain and call in SERT is often the preferable one when a situation transitions to a potential barricade. (p.41)*

6 *As part of its internal investigative protocols, Bureau investigators should strive to interview all witness officers from other agencies; if such interviews prove not feasible the investigation should indicate why. (p.42)*

7 *The Bureau should consider whether some work place limits should be placed on specialized units' engaging in high risk operations so that fatigue will not impact decision making and potentially compromise officer safety. (p.44)*

8 *The Training Analysis should be privy to and reference any prior deadly force incidents by officers when analyzing the incident at issue. The analysis should look for commonalities of officer performance between the incidents. (p.46)*

9 *Board should consider whether there are significant parallels between the officer's tactical decision making in the two incidents and, if so, whether they suggest additional remedial action. (p.46)*

10 *The City should consider requiring BOEC dispatchers to attend Critical Incident Management Training. (p. 55)*

11 *As part of its investigative protocols, the Bureau should inquire of the medical examiner about the survivability potential of any downed subject who is not provided immediate medical attention. (p.64)*

12 *The Bureau should ensure that its investigative protocols for investigating critical incidents require personal examination of video surveillance systems as opposed to reliance on non-Bureau member's statements about whether there was a video capture of the event. (p.67)*

13 *The Bureau should consider developing and formalizing a more personal and robust way to communicate the results and deliberation of the Police Review Board recommendation and Bureau findings to involved officers. (p.68)*

14 *The Bureau should consider revising its investigative protocols to require Detectives and/or IA Investigators to obtain the records regarding the subject's post-incident medical treatment following any non-fatal officer-involved shooting investigation. (p.73)*

15 *The Bureau should consider revising its Canine Standard Operating Procedures to limit the deployment of canines to the apprehension of subjects suspected of committing serious or violent felonies. (p.87)*

16 *The Bureau should consider revising its policy and/or training to require officers to consult emergency medical response personnel prior to transporting subjects who claim to be having difficulty breathing or to be in some sort of medical distress. (p.89)*

17 *The Bureau should consider revising its investigative protocols to require that investigators interview all witness officers in any in-custody death investigation. (p.92)*

18 *The Bureau's Detectives and IA investigators and its reviewers in the Training Division, Executive Staff, and Police Review Board should be reminded to address all potential policy violations and tactical issues, even where those issues did not directly lead to the outcome in the given incident. (p. 93)*

19 *The Bureau should consider whether to modify or eliminate the Commander's Memorandum as part of the review process for officer-involved shootings and in-custody deaths. (p.99)*

20 *The Bureau should consider whether mechanisms or orientation should be revised to increase stakeholder involvement in identifying and resolving issues worthy of discussion for the Review Board. (p.101)*

21 *The Bureau should consider whether the Review Board process focuses sufficiently on officer performance, not only with regard to the decisions to use deadly force, but also on the question of whether tactical decision making merits remediation through discipline or other alternative means. The Bureau should consider developing practices or protocols to ensure that the Review Board addresses issues and renders judgment regarding tactical performance and decision making. (p.102)*

Responses to the Report

CITY OF PORTLAND, OREGON

Bureau of Police
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Integrity • Compassion • Accountability • Respect • Excellence • Service

November 17, 2014

LaVonne Griffin-Valade
City Auditor
1221 SW 4th Avenue, Room 140
Portland, OR 97204

Dear Auditor Griffin-Valade:

I appreciate the opportunity to review and respond to the third report and recommendations from the OIR Group regarding Portland Police Bureau officer-involved shootings. Over the past several years, PPB has made significant changes to our policies, procedures, and training that we provide to our officers and supervisors. Therefore, when looking at the 21 recommendations in this third report that stem from shootings that occurred three to eight years ago, we cite many changes that have been implemented for a few years.

In this report, the OIR Group discusses a recommendation made by the Police Review Board (PRB) that was not implemented due to an oversight. It is important to note that the Bureau receives recommendations from OIR, the Auditor, the PRB and now the Department of Justice (DOJ). We now have a mechanism through our Inspector where these are tracked to ensure proper accounting of these recommendations. We are tracking 378 total recommendations in our system, of which 174 have been completed and 204 are open and assigned. Of those open, 99 are from DOJ. In regard to PRB specifically, 141 recommendations have been made, with 91 of them completed and 50 still pending.

Many of the shootings reviewed occurred under very challenging circumstances and include one where officers were shot and others where officers and the community were at grave risk. During these rapidly unfolding events, officers performed commendably and relied on the high caliber of training they have received. While we agree with the majority of the recommendations, we have concerns with some of the tactical analysis and conclusions drawn in this report. We look forward to continued discussion with the members of the OIR Group regarding these concerns.

As you know, the Police Bureau conducts a thorough training analysis after each officer-involved shooting. This is combined with the investigations from the Internal Affairs Division and Detective Division and presented to the PRB. There will always be room for enhancements, and we appreciate the collaborative effort the OIR Group has taken to add another layer of transparency and understanding of these traumatic events.

Sincerely,

Michael Reese

MICHAEL REESE
Chief of Police

MWR/tws

Portland Police Bureau Responses to OIR Group 3rd Report to the City of Portland
Portland Police Bureau Officer-Involved Shootings

1. *The Bureau should examine its current processes to determine whether there is a sufficiently robust system ensuring that recommendations emanating from its review of use of deadly force incidents are implemented.*

Agree – Current Practice. On May 30, 2012, the Professional Standards Division created an Action Item Database and Standard Operating Procedure #4 that documents and tracks formal recommendations proposed to the Chief of Police by internal and external sources, including recommendations made by the Police Review Board.

2. *The Bureau should consider adopting protocols where the Police Review Board routinely revisits past reviews to obtain feedback on the implementation and effectiveness of its recommendations.*

Agree to Review. – The Professional Standards Division currently has the ability to track recommendations from the date of assignment to completion. The Bureau will review current Police Review Board protocols to determine how best to document the effectiveness of its recommendations. However, it is important to note that PRB board members change and therefore, these discussions would not necessarily be the members who discussed them initially and could provide a context in which they were made.

3. *The Bureau should again consider whether it is beneficial to the interests of the City to have the East County Major Crimes Task Force involved in investigations of PPB officer-involved shootings.*

Disagree in part. – The Police Bureau recognizes the need to improve on how the East County Major Crimes Team (ECMCT) has been used in past officer-involved shooting investigations, due to issues with consistency and quality of investigations. We believe, though, that it is imperative to have external investigators involved in critical aspects of the investigations. The role for ECMCT assists in our investigation by allowing for external perspectives as well as legitimacy in the eyes of the community. ECMCT allows for a higher level of transparency and provides our regional partners the opportunity to build competency.

4. *If there is uncertainty regarding whether PPB can issue communication restriction orders to officers involved in off-duty shooting incidents unless an Internal Affairs investigation is opened, the Bureau should revise its policies so that communication*

restriction orders are issued in all shootings involving PPB personnel, regardless of whether the shooting is on or off-duty.

Agree – Current Practice. The current draft of Directive 1010.10, Post Deadly Force Procedures [which is current practice], defines Police Action in specific reference to the Use of Deadly Force as: "Any circumstances, on or off duty, in which a member exercises official authority." The PPB currently issues communication restriction orders to all witness and involved members in all shootings involving PPB personnel, regardless of whether the shooting is on or off duty. This directive was significantly revised in 2005 and the title was changed to Deadly Physical Force in 2007.

5. *The Bureau should ensure that policy and training convey a clear message that the option to tactically reposition, contain and call in SERT is often the preferable one when a situation transitions to a potential barricade.*

Agree – Current Practice with need of adjustments (current practice in training; review policy to include new language).

The Bureau currently teaches tactical disengagement to officers and sergeants in the Critical Incident Command course. As part of their training, sergeants are encouraged to consult SERT/CNT when facing a potential barricaded suspect when there is a threat of weapons.

The use of the term "preferable" is problematic, as it does not take into account the individualized nature of these complex calls. While the use of a tactical team and a strong presence is often needed on a barricaded subject, there are times where having the tactical team on-scene creates unwanted pressure on the suspect. In addition, Portland Police encounter many barricaded subject situations where no other parties are in danger and supervisors disengage from the call. These calls often involve suicidal subjects who are armed. The majority of our barricaded subject calls do not rise to the level of a SERT/CNT activation, and instead benefit from a follow-up visit from our Behavioral Health Unit team.

Language should be added to the policy similar to: "SERT/CNT provides additional expertise and specialized equipment to help resolve exceptional situations safely. Supervisors are encouraged to consult with SERT/CNT when the incident does not rise to the level of a mandated SERT/CNT activation."

6. *As part of its internal investigative protocols, Bureau investigators should strive to interview all witness officers from other agencies; if such interviews prove not feasible the investigation should indicate why.*

Agree – Current Practice. Although in the incidents identified in the report may differ, the detectives who investigate officer-involved shooting cases attempt to interview all witnesses known at the time of the investigation. If additional witnesses are identified during the administrative investigation, detectives should be informed of the presence of those witnesses to ensure those interviews are vetted for the potential use in a criminal investigation.

7. *The Bureau should consider whether some work place limits should be placed on specialized units' engaging in high-risk operations so that fatigue will not impact decision making and potentially compromise officer safety.*

Agree – Current Practice. The Bureau expects Bureau supervisors to actively monitor their employees whether they are in specialized units or on patrol. Supervisors should evaluate an officer's ability to perform his/her required duties. In specialized units, such as SERT or the Gang Enforcement Team, during missions, sergeants evaluate officers for both physical and mental fatigue and make arrangements as necessary in order to accomplish the incident in the most effective manner possible.

Due to the unpredictable nature of tactical events, it is in the city's best interest to allow the issue of sleep deprivation to be addressed and managed by the on-scene supervisor. We will reinforce this issue with supervisors; however, through a Chief's Executive Order.

8. *The Training Analysis should be privy to and reference any prior deadly force incidents by officers when analyzing the incident at issue. The analysis should look for commonalities of officer performance between the incidents.*

Agree to Review–Disagree on proposed changes. We agree that the Police Bureau should analyze officer performance in every instance, and that all commonalities should be explored. We further agree this level of analysis would help inform our annual needs assessment and the development of future training courses.

However, the primary purpose of the Police Review Board is to provide a recommendation to the Chief of Police on whether or not the member's use of force was within PPB policies. As this recommendation could ultimately result in discipline, it would not be appropriate to discuss any prior acts, good or bad, until the board has evaluated the current case on its own merits and arrived at a conclusion. If the Police Review Board finds the member's actions out of policy, our current practice is to then share the member's history to help inform the board's recommendation for corrective action.

9. *Board should consider whether there are significant parallels between the officer's tactical decision-making in the two incidents, and, if so, whether they suggest additional remedial action.*

Agree to Review – The Professional Standards Division will review the threshold alerts that identify Traumatic Incidents in the Employee Information System (EIS), and will ensure that Officer Involved Shooting incidents are included as an alert prompting a review and/or referral by the Professional Standards Division.

10. *The City should consider requiring BOEC dispatchers to attend Critical Incident Management Training.*

Agree in concept – We are currently working on cross-training opportunities which will cover both types of training: the training that dispatchers at BOEC currently receive and the training that patrol officers and supervisors receive. Discussions in regard to BOEC instructing at the PPB's Advanced Academy are underway to complement the proposed cross-training. We continuously evaluate our training and processes to include inter-departmental effects. The decision to require critical incident management training for BOEC employees ultimately lies with the Commissioner who oversees BOEC and the Director of BOEC.

11. *As part of its investigative protocols, the Bureau should inquire of the medical examiner about the survivability potential of any downed subject who is not provided immediate medical attention.*

Disagree – The Police Bureau has the ability to make the inquiry regarding the potential survivability of injuries sustained by the use of deadly force; however, such information from the medical examiner (if they chose to provide it) would at times be speculative. It is the current practice during the post mortem to inquire about the lethality of the injury. Each injury sustained has been categorized as lethal or non-lethal based on the location and severity of the injury.

In looking at this recommendation, it is important to note that the Police Bureau seeks to provide medical attention as soon as it safely possible. Over the years, the Bureau has made significant changes in how it provides medical attention to those impacted by deadly force encounters. In August 2010, the Police Bureau implemented the use of ballistic shields which are carried in all of the sergeants' cars. The Training Division has developed scenario-based training which specifically calls for the deployment of the ballistic shield during post shooting incidents. The use of these shields has had a significant result in reducing the amount of time it takes to secure the subject so medical aid can occur.

We recognize the sanctity of life, but we must also gauge the effectiveness and risk when attempting to provide immediate medical attention to a downed subject. We want officers to proceed with a level of caution as to not provoke additional deadly force. Medical response should occur when making an approach is safe for all of those involved, including the injured subject.

12. *The Bureau should ensure that its investigative protocols for investigating critical incidents require personal examination of video surveillance systems as opposed to reliance on non-Bureau member's statements about whether there was a video capture of the event.*

Agree -We understand it is best practice to have investigators actually view potential evidence to determine the existence or exclusion of evidence. Absent an exception to the warrantless search, detectives will follow the proper protocol for making application for a warrant to seize and ultimately search such evidence should it exist.

13. *The Bureau should consider developing and formalizing a more personal and robust way to communicate the results and deliberation of the Police Review Board recommendation and Bureau findings to involved officers.*

Agree – Current practice per Executive Order 336.00: The Professional Standards Division Captain personally notifies the subject member or the subject member's representative and the Chief of Police, of the Police Review Board's recommended findings by the end of the day.

14. *The Bureau should consider revising its investigative protocols to require Detectives and/or IA Investigators to obtain the records regarding the subject's post-incident medical treatment following any non-fatal officer-involved shooting investigation.*

Agree – Given the current state of medical information, investigators from the Detective Division should attempt to obtain (request) medical information on non-fatal shootings. This request would follow proper protocol for obtaining records.

15. *The Bureau should consider revising its Canine Standard Operating Procedures to limit the deployment of canines of the apprehension of subjects suspected of committing serious or violent felonies.*

Disagree – While we recognize the negative stigmatism that has historically been attached to the use of police K9's, the K9 is a superior locating tool, which is their primary function within the Portland Police Bureau. In addition, canines are used more frequently as a de-escalation

tactic in force events. While many agencies train to a *find and bite standard* (when the dog tracks and locates a suspect the dog is trained to bite the suspect), the Portland Police Bureau K9 Unit has trained and deploys to the *guard and bark standard* (police dog is used as a locating tool and is trained to only bite a suspect under very specific circumstances). This high-level standard is consistent with the national best practice recommended by the International Association of Chiefs of Police**.**

We believe that limiting canine deployments to serious or violent felonies is not the intention of *Graham v. Connor*, (as cited in the report) and would lead to increased dangers for suspects and officers alike. There are multiple K9 force court cases that were adjudicated under *Graham v. Connor* for misdemeanor or what would be considered minor crimes where the courts found the K9 use of force was reasonable. (They are attached in the Amendment of this document.)

The K9 Unit is a valuable and proven less-lethal force option available to patrol officers and investigators. Canine handlers are subject to the Police Bureau's force policies and applicable directives with a thorough review of canine use of force after every force event (the handler, the canine, and the team as a whole are assessed).

16. *The Bureau should consider revising its policy and/or training to require officers to consult emergency medical response personnel prior to transporting subjects who claim to be having difficulty breathing or to be in some sort of medical distress.*

Agree – Current Practice. The PPB will review Directive 630.45 and consider adding language addressing those subjects who claim to be having difficulty breathing or be in some sort of medical distress.

17. *The Bureau should consider revising its investigative protocols to require that investigators interview all witness officers in any-in custody death investigation.*

Agree – Current Practice. Professional Standards Division SOP#7 requires Internal Affairs investigators to interview all witness officers in any in-custody death investigation.

18. *The Bureau's Detectives and IA investigators and its reviewers in the Training Division, Executive Staff, and Police Review Board should be reminded to address all potential policy violations and tactical issues, even where those issues did not directly lead to the outcome of the given incident.*

Agree – Although the current practice has been to have detectives ask questions of supervisors and others involved in the tactical planning to determine if it falls within training protocol, we have had some vibrant discussions regarding who should be performing these interviews. We

believe detectives should ask all questions surrounding the incident and the criminal investigation while Internal Affairs investigators should perform interviews regarding policy and training.

19. *The Bureau should consider whether to modify or eliminate the Commander's Memorandum as part of the review process for officer-involved shootings and in-custody deaths.*

Agree in part – The Commander's Finding Memorandum is the framework for the analysis by the Police Review Board, the Assistant Chief's and the Chief of Police. Currently, this memorandum provides a mechanism for the Commander to analyze, evaluate, and memorialize the evidence and testimony gathered during the administrative investigation, the criminal investigation and/or Grand Jury transcripts, and the Training Division's review of the case. The areas covered include but not limited to the analysis of the decision to use lethal force; the analysis of the operational planning and actions; and the analysis of the post shooting procedures in this case. This memorandum is critical in the continued effort to learn and improve organizational training and policy.

We agree that the issue regarding its timeline can be shortened and we have combined this effort to be in compliance with the rest of the review system. As with our response to recommendation #31 from OIR Report #2, we have modified the Commander's Finding Memorandum to assist in not only keeping with timelines, but to ensure all the pertinent issues are identified and addressed.

20. *The Bureau should consider whether mechanisms or orientation should be revised to increase stakeholder involvement in identifying and resolving issues worthy of discussion for the Review Board.*

Agree to review – The Professional Standards Division (PSD) will review the protocols and direction given to advisory and voting members during the time period prior to the Police Review Board (PRB) meeting date.

The IPR Director and the PSD Captain review all of the investigative materials prior to convening a Police Review Board. The Professional Standards Division currently provides civilian and peer members with a Case Review Checklist that includes reviewing the Internal Affairs Investigation, Detective Division Investigation and the Training Division Analysis. Those members are encouraged to provide feedback prior to convening the Board. Other professional stakeholders [advisory members] have the opportunity to provide feedback prior to the Board and have done so in the past. The PPB will continue to encourage this practice.

21. *The Bureau should consider whether the Review Board process focuses sufficiently on officer performance, not only with regard to the decisions to use deadly force, but also on the question of whether tactical decision making merits remediation through discipline or other alternative means. The Bureau should consider developing practices or protocols to ensure that the Review Board addresses issues and renders judgment regarding tactical performance and decision making.*

Agree– Current Practice. The Police Review Board process currently includes providing the Division Commander or Captain with Areas of Review when making a recommended finding that include the following: Operational Planning, The Application of Deadly Force, Post Shooting Procedures, Supervisory Response and Tactical Response.